Beyond Burnout

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Contents

Tables

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Statement

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Abstract

This thesis explores the socio-cultural and political construction of the concept of burnout and the effects of this on nurses. The way burnout is conceptualised affects how it is dealt with, and how those suffering burnout are treated.

In spite of identifying a number of work related stressors nurses have not been able to address the work related issues that cause burnout. This is related to the nature of nursing. Nursing is an oral culture and involves body care and is seen as women's work and dirty work. This socio-cultural aspect of nursing serves to subordinate nursing to medicine in the occupational division of labour, and in the treatment of burnout.

Economic conditions in the workplace are such that workers are expected to do more with fewer resources. This has impacted on nurses' well-being. Nurses suffering from the effects of prolonged workplace stresses as a result of economic rationalist management are subjected to medical dominance when seeking to address their symptoms. Nursing subordination is on the level of knowledge, gender and power. In the role of client the symptoms of work related stress are re-articulated as personal problems requiring a medical solution.

In this study, discourse analysis of a text on burnout is used to illustrate the underlying structure, process and powerful interest groups involved in the treatment of burnout. Through discourse analysis and critique, how burnout is constructed, managed and treated, and how this process serves to dis-empower nurses, is exposed.

As a result of the critique, strategies to empower nurses have been suggested. These strategies relate to peer support, addressing workplace problems, adopting a new perspective and political action. The adoption of these strategies may enable nurses to move the debate on burnout beyond the present boundaries and address the workplace issues that impact on nurses' well-being.

Chapter 1

Introduction

1.1 Overview

This thesis explores the socio-cultural and political construction of the concept of burnout and the effect of this on nurses. The way burnout is conceptualised in society affects how it is dealt with, and how those suffering from burnout are treated. The primary concerns are:

- how the problem of burnout is constructed, and
- how this construction is addressed from the socio-cultural and political aspects in the work environment, and
- how this impacts on nurses, that is the nurses suffering burnout and other nurses not suffering burnout.

An understanding of this conceptualisation and the underpinning power structures will enable nurses to move beyond the present situation where nurses become 'burnt out' as a result of workplace issues impacting on their wellbeing. In the past nurses have relied on other professionals to address the problem of burnout and this has resulted in the solution reflecting the needs of the profession that is addressing the problem. This has not necessarily provided a solution that has addressed the problem of burnout for nurses. By exposing how burnout is constructed and the effects of this on nurses other solutions to the problem of burnout can be proposed that are supporting to nurses, thereby allowing nurses to move beyond their present situation.

In this chapter the problem of burnout is introduced and explored in terms of how it is defined and treated within society. The research problem is identified in the context of research and data on burnout in nursing, and the limitations of the study are identified. Key terms relating to burnout are examined, and a case study is used to illustrate the problem of burnout for nurses. The experience of burnout illustrates the impact of workplace stress on the individual nurse, his/ her career and the community.

To conclude, an outline of this thesis is presented which provides a description of the contents of each chapter.

1.2 Context

In spite of nurses identifying the work related problems that have a negative impact on their well-being, burnout continues to be a problem. Nursing management strategies have identified the changes that need to occur in the workplace, but nurses have been unable to move beyond this identification to addressing the problems that impact on their health (Lewis & McLin 1991; Robinson, et al. 1991). This is due to the lack of power that nurses have in the workplace, which is related to the work that they do and to the social, cultural and political role that nurses have in society.

In today's modern capitalist society work plays an important role in people's lives. It occupies a major part of our waking hours and is often the core of our sense of self. It is therefore not surprising that how we cope with our work has an impact on our feelings of self-worth and well-being. Difficulties arising from our work environments can have adverse effects on our health. Prolonged negative stress caused by the work

environment can result in 'burnout'. Burnout has been defined as a process in which the professional's attitude and behaviour changes in negative ways in response to job strain (Cherniss 1980).

1.3 The research problem

Researchers have identified work environments that nurses find stressful, specific work situations that nurses find stressful, and management strategies that are helpful in reducing nurses' stress in the workplace (Robinson, et al. 1991). There has also been discussion on the official strategies of dealing with a nurse who is 'burnt out', and these have led to discussion on the social, cultural and political implications of the sickness role.

Much has been written about burnout in nursing and how to manage it, most of the treatment has centred on the medical model and has been dominated by medical ideology. This has impacted on how burnout has been conceptualised and managed.

According to Kress (1995) linguistic and social processes are totally connected; the individual being a social agent located in a network of social relations. Texts are the individual writer's attempt to be a social agent and are instrumentally and causally involved in the process of language construction and change. Each text can therefore be seen as the individual writer's attempt to resolve differences.

Language is articulated in systemic ways or discourses. Texts arise out of specific social situations and are constructed for specific social purposes. A self-help text on burnout is therefore part of a specific genre of self-help texts. These genre provide a specific index and catalogue of the relevant social occasions of a community at a given

time. Thus a text provides an example of both a discourse and genre. The discourse carries meanings about the nature of the social context from which the text is derived and the genre carries meanings about the conventional social occasion from which the text arises.

A text on burnout will therefore provide an example of how burnout is constructed within society, the specific purpose of this construction, and how possible differences are dealt with. To explore the social construction, a discourse analysis of a contemporary text on burnout will be undertaken. The text selected is *Burnout* by Ken Powell (1993).

No text is the text of a single writer as 'all texts show traces of differing discourses, contending and struggling for dominance' (Kress 1985). Texts are therefore the sites of struggle and the sites of linguistic and cultural change. Through discourse analysis it is possible to expose the relationship between language and ideology at a contextual and textual level and provides a way of exploring the relationships of power that are encoded within the text. As a methodology, discourse analysis is pertinent as it exposes the ideological dimensions of the care provider and the client relationship and how burnout is constructed within its socio-cultural and political context.

A critique of this construction of burnout offers nurses a way of addressing burnout by:

- assisting in the treatment of nurses suffering burnout by addressing issues that are important to them;

- helping nurses understand the work environment so that they can minimise the occurrence of burnout; and

- inducing change in work practises, and in the organisation of the work environment.

A critique of how burnout is conceptualised and treated in society exposes the powerful groups in society and how they construct problems to support their own interests. A critique of a text on burnout will thus offer nurses a way of moving beyond the present situation to address the politics in the workplace that affect how nurses are treated.

1.4 Limitations of this study

A major limitation of this study is that the outcomes are not definitive. The discourse analysis may be subject to further analysis and critique. The process of critique enables discussion and enlightenment which is the dynamic essence of the socio-political perspective.

This study is limited in that it is being carried out in isolation, that is specific to one book. The results are therefore limited to this study and cannot be generally applied. However the same methodology of discourse analysis can be applied to other material for a wider application.

Medical dominance is not the only method of dealing with burnout. The dominance of medicine is subject to being contested and usurped at any time and by a number of other professionals and professional groups and particular individuals do not necessarily take this approach. However, this approach is demonstrated in Powell's book and is the favoured approach taken by the Workers Compensation system and most health care facilities.

1.5 Examination of key terms

Burnout is defined as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment. Emotional exhaustion is a state in which the person feels emotionally overextended and drained. Depersonalisation is where the person feels negative in attitude, this often presents as the person being insensitive towards others. Reduced personal accomplishment manifests as a person having a decline in his/her sense of competence with feelings of inadequacy, failure, loss of self-esteem and depression (Maslach & Jackson 1981; Maslach 1982).

A number of themes emerged from the literature on burnout. Firstly, there is no clear agreement on what the cause of burnout is, but there are a number of identified work situations that contribute to the problem. Secondly, most of the literature on the treatment of burnout focuses on the individual's response to stress and adjusting the individual's responses to the stressors. Thirdly, as there are no standardised treatments for burnout, there are no standardised evaluations of interventions. This seemingly ad-hoc approach and focus on individual treatment and individual studies of environments prevents a uniform approach. There is no way of knowing in what social conditions burnout is always likely to occur, how often it will occur, and to whom it is most likely to occur.

This is because workplace stressors are perceived differently by individuals according to their life skills, experiences and resources. Most people are able to balance their stress level so that it does not impact negatively on their wellbeing, but in the case of burnout the individual reaches a state of physical, emotional and mental exhaustion as a result of experiencing excessive negative stress in the workplace.

1.6 The experience of burnout

To illustrate the experience of burnout, an article written by Julia Cornwall (1991) is used. This article is titled 'Opting out of burn-out' and appeared in the *Nursing Times*, May 1991. Julia Cornwall is one of the nurses that Powell (1993) has included as a case study in his book, *Burnout*.

In this article Cornwall described her personal experience of burnout and the impact it had on her life and career. Burnout is conceived in four stages:

1. Beginning with the individual's enthusiasm and motivation becoming dulled, stagnation sets in.

2. The person gradually becomes cynical and frustrated.

3. Withdrawal from the workplace takes place.

4. The victim feels totally unable to work.

Julia Cornwall is a nurse with over 20 years experience in the British National Health Service. She spent eight years as a leg ulcer specialist and research nurse. In this position, she worked in collaboration with the consultant vascular surgeon providing nursing care to patients suffering from leg ulcers. Her work is recognised both in England and Abroad, and she has been awarded the Florence Nightingale award.

Organisationally the position that Cornwall occupied in the workplace was graded as a Level 1 nurse in the clinical grading structure. This grading reflected the clinical expertise needed to do the position.

Disillusionment occurred in the sixth year as an Ulcer Specialist when she wanted to set up a training course on ulcerative limbs for nurses within the hospital. This course would have brought in some much needed money for the vascular unit for equipment or more nursing help. She approached the school of nursing and was told that she would have to gain passes in three more pre-tertiary subjects before being considered for the necessary teacher training. She felt that this was a personal attack, considering her expertise in the field and the clinical teaching role of her position.

Over time the economic conditions in the workplace changed. Nursing care treatment and non-prescription items became difficult to obtain, and this impacted on the care of people with leg ulcers. Economic conditions in the workplace were such that they impacted on her nursing care in such a way that Cornwall was unable to provide the level of care she saw as essential to her clients. Furthermore nursing administration added to the stress by increasing her workload by requiring her to document all her client data on a computer database. Cornwall foresaw that this information would result in further cutbacks in patient services as economic rationalisation of services occurred. Increased scrutiny on budgets increased the nurse's stress, and impacted on her performance.

Nursing management did offer emotional support, but it was too late. In spite of the nurse working harder, and for extra hours, the workload was too much and the nurse had already used up all her personal resources to cope with the workplace situation. 'I was already working well over my $37\frac{1}{2}$ hours - a normal occurrence for most nurses' and 'There was no point in my assessing a patient if I could not give them appropriate supplies' (Cornwall 1991, 34). Consequently, the only option for the nurse was to move out of the position which was causing her to become stressed into a lower status position that was less stressful.

From a nursing perspective, the workplace lost a highly skilled and hard working nurse. The community also lost in that when she had the necessary nursing supplies to do her work, the nurse was able to save the community money by reducing acute admissions to the hospital. The patients supported through this nursing practice, would have had appropriate care that was relatively cheap, and this would save the hospital acute care beds in the long term.

Cornwall's position, as an ulcer specialist nurse became subservient to that of the administration of casemix, in that nursing management, although sympathetic, was not powerful enough to address the workplace problems that affected both Cornwall's well-being and patient care. The problems of a lack of nursing resources were justified through managerial discourse and economic rationalism. Within the workplace areas of possible conflict related to the unequal distribution of resources were discursively re-articulated as personal problems of the victim of burnout, and the social conditions that caused the problem were not addressed.

1.7 Thesis outline

This thesis is divided into six chapters.

Chapter 2, Burnout and nursing environments, includes a review of the literature on burnout in which a number of recurrent themes are identified. These themes describe links between stress and burnout, the concept and symptoms of burnout, strategies to manage stressful situations which are likely to cause burnout, and the environments in which burnout is likely to occur. Within these themes are sub-themes of the 'vocabulary of complaint' and alternatives to the medical model of

treatment.

Chapter 3, Discourse analysis, describes and justifies the process used in the critique of a text on burnout. The text that is critiqued, is *Burnout* written by Ken Powell (1993).

Chapter 4, The construction of burnout, addresses the conceptualisations of burnout within the text. These conceptualisations are from the perspectives of: the clinical psychologist, the nurses being treated by the clinical psychologist, and the reader of the text. This chapter focuses on the purpose of self-help genre, the construction of the book, preferred meanings, the nature of burnout, stress and burnout, the nature of organisations, the concept of nursing and interventions.

Chapter 5, Interpretations, focuses on the interpretation of burnout in Powell's text from the social, political and cultural perspectives and the effect of this on the nurses suffering burnout.

Chapter 6, Beyond burnout, identifies what nurses can do as a way of addressing the problem of burnout from a nursing perspective. It provides a basic outline of what must be accomplished in order for the workplace issues to be addressed and suggests strategies for nurses to empower themselves on a political level so that they can move beyond their present situation and address the problem of burnout.

1.8 References

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Chapter 2

Burnout and nursing environments:

A review of the literature

2.1 Overview

The literature reviewed identified a number of recurrent themes including:

- description of the symptoms of burnout from a treatment perspective, and the identification of strategies to overcome contributing stressors;
- identification of strategies to manage stressful situations; and
- assessment and identification of different environments in which burnout is likely to occur.

Within these themes two sub-themes emerged:

- the 'vocabulary of complaint' (Turner, 1987) which was focussed upon as the primary method of coping with stressors; and
- alternatives to the medical model of treatment were identified.

Most of the literature reviewed came from North American and British health journals, and focused on the treatment perspective of burnout. The Australian nursing journals tend to reinforce research undertaken overseas. In general, articles written in the 1970s focused on the measuring of the phenomenon of burnout in different work settings (a clinical psychologist perspective). The articles in the 1980s focused on the management strategies (that is a nursing management perspective),

and the 1990s on alternatives methods of managing burnout (other than the medical model).

In this chapter the literature reviewed demonstrates the conceptualisation of burnout in contemporary society. Nursing occurs within a social structure, and is influenced by economic and cultural conditions within society.

The key issues explored within this chapter are:

- The concept of stress, and the links between stress and burnout.
- Nursing environments and their relationship to burnout, with reference to medical dominance and nursing compliance.
- Strategies employed by nurses to deal with the stress associated with their work, with reference to Turner's (1987) vocabulary of complaint.
- Alternative models of addressing burnout other than the medical model.

A critical analysis of strategies that nurses have employed to address burnout illustrates how these strategies have failed to address the problem of burnout in nursing because they fail to address the workplace issues that cause burnout to occur.

Alternative models to the medical model of treatment have been suggested as ways of addressing the problem of burnout, in most cases these alternatives are extensions of the medical model from a different professional perspective. For example, a psychological, alternative therapy or self-help perspective.

Recently, economic conditions, brought about by economic rationalist policies, have impacted on the workplace and the individual in such areas as the distribution of

resources, and the distribution and value of work and workers. Within health, these policies have impacted on the work environment and the content and structure of workloads, which have affected nurses' well-being. Health care services are socially constructed and support a medical dominant model of operation. This dominance is not total but subject to contestation.

The nature of nursing work involves body care and, as such, is not seen as valuable by society. Nursing has been subordinated to medicine on the level of knowledge, gender and the nature of work. Within the workplace nurses have developed alternative ways of dealing with this dominance. The work that nurses do is by nature stressful, and nurses have developed ways of dealing with the stresses they experience. Where negative stresses have impacted on the well-being of nurses and resulted in burnout, nurses have looked at strategies to deal with these. Nursing burnout strategies have focused on the individual, the work environment and management. Although alternative strategies have been proposed and developed on closer inspection they too follow the medical model and fail to address workplace issues.

2.2 Stress and burnout

The concept of stress was added to our language and developed by Hans Selye (1936; 1956; 1982), who looked at the link between physiological and psychological stressors. From his experiments with animals he concluded that the patterns of physiological arousal were largely the same regardless of the type of stress, and were thus non-specific. In the 1940s he decided to call this non-specific response stress. Later in his career he noted that it would have been better to use the word strain to

refer to the body's response to noxious stimuli and the word stress to refer to the noxious stimulus events. As he put it: 'My English was not yet good enough for me to distinguish between the words "stress" and "strain"' (Selye 1976, 50).

The term stress has had different emphases according to different theorists. For example, Buss (1966) and Maher (1970) viewed stress as the effect of stressors acting on the individual. Selye (1976) defined stress as a response of physiological arousal brought about by a troublesome event. The transactional model of stress, as advocated by Lazarus and Folkman, viewed stress as neither a stimulus nor a response, but a stimulus-response transaction in which one feels threatened. They argued against stress as a response of physiological arousal because it is possible to experience arousal in the absence of stress (Lazarus & Folkman 1984).

Antonovsky (1979) viewed stress as evolving from exposure to stressors. He distinguished between stressors and routine stimuli. A routine stimulus is one to which the person responds more or less automatically. This is not to imply that the stimulus is exactly the same as previous stimuli, but rather that one can incorporate a new stimulus into an existing framework. This allows the person to respond in a routine fashion. It presents no problem in adjustment. A stressor is defined as a demand made by the external or internal environment of an organism that upsets its homostasis. Restoration depends on a non-automatic and not readily available energy-expending action (Antonovsky 1979).

A routine stimulus can become a stressor under certain circumstances. It is not always possible to determine when and why this happens. There are also individual differences, that is, individuals may perceive stressors differently. A phenomenon may be experienced as a stressor or stimulus, depending on the meaning that the

person has at that point of time. It is also dependent on the repertoire of coping mechanisms that the individual has available to him or her.

Lazarus and colleagues (1978; 1980) and Lumsden (1981) developed the stress theory to include the physiological, psychological, and behavioural levels of analysis. Lazarus's model of stress is that it is viewed as an on-going process affected by individual personality factors and environmental variables. The individual is viewed as constantly responding to, and interacting with, the environment. Whether the stress is a benefit or a harm to the individual depends greatly on the individual's cognitive appraisal of the stress, and the subsequent coping process. Life is dependent upon an organism maintaining itself at the cellular level in a state of tension with the environment. Stress is not always perceived as negative but it is the negative stress that is damaging (Weiten et al. 1991).

The person-environment fit theory proposes that health strain results where there is a misfit between the individual and the work environment. The concept of fit or compatibility and the environment is used to define job stress and strain. Coping is the individual's activity directed to changing the objective environment or changing the individual to improve the fit. Stress is experienced when the environment either does not provide or threatens not to provide the goals which the individual seeks (Van Harrison 1978). In life, stressors are not limited and do not necessarily come one at a time, more often than not they affect a system already under strain. Burnout can be understood as the result of prolonged work-related negative stress that depletes the individual's resources and ability to cope.

The term burnout was first used in professional literature by Freudenberger, a clinical psychologist, in 1974, and it appeared in the nursing literature in 1978. It was

included in the Cumulative Index to Nursing and Allied Literature in 1980 (McConnell 1982). This term was readily accepted by nurses as a way of identifying experiences arising from work-related stress.

The term 'burnout' is not a medical diagnosis. In the medical profession the symptoms of burnout are described in terms of behavioural maladjustment.

Burnout has been researched by behavioural scientists in the areas of nursing and clinical psychology. Pines and colleagues described burnout as a syndrome that involves physical, mental and emotional exhaustion that is attributed to work-related stress (Pines & Aronson 1988; Pines et al. 1981). Many nursing researchers have studied burnout in nurses. These include Branco et al.(1981), McAbee (1991), Chiriboga and Bailey (1986), Constable and Russell (1986), and Robinson et al. (1991).

Weiten et al. (1991, 80) advanced the concept of stress and its relationship to burnout. Burnout involves physical, mental and emotional exhaustion that is attributed to work-related stress. The physical exhaustion includes chronic fatigue, weakness and low energy. The mental exhaustion is manifested in highly negative attitudes towards oneself, one's work and life in general. The emotional exhaustion includes feeling hopeless, helpless and trapped (Weiten et al. 1991, 80).

Burnout is thus conventionally considered to be the result of chronic job-related stress which does not occur as a result of a few traumatic events but is a general erosion of the spirit over time (Pines et al. 1981, 3).

Broad use of the term stress has lead to the word being used to refer to a stimulus, a response, and/or a stimulus-response transaction. Stress in the workplace has been

researched by a number of clinical researchers in the areas of behavioural sciences and nursing. These researchers have concluded that some stress is necessary for a person to function, but that excessive negative stress can have adverse physical effects on an individual. Stress is not a problem until it is perceived, by the individual, as being more than they can cope with. Burnout is the result of chronic job-related negative stress.

2.3 The economic context

In recent years health care services have undergone major restructuring. There have been many rapid changes in technology as well as in the administration and clinical structures of service provision. The economic climate is such that workers are now required to do more with fewer resources (Davis 1993). This puts pressure on the nurses and this pressure flows through to the interactive relationship between the individual and workplace needs, wants and services. In many ways, exposure to physical, psychological and social stimuli within the workplace has had a positive effect on nurses, but it can also impact negatively on the individual's well-being, especially over a long period of time. This can result in the physical, mental and emotional resources of the person becoming depleted, and the nurse becomes 'burnt out'. Nursing literature on burnout in the 1980s and 1990s has focused on the management of resources so as to prevent burnout occurring but this has not been successful in preventing burnout in nursing.

In the 1990s, discourses of health services have become focused on being responsive to users' needs, and have become more open to public participation. Yet the present economic environment is such that there is an emphasis on cost-effectiveness. Doing

more with less is now seen as the main attribute of good public administration in all areas including the provision of health services.

The economic pressures in the workplace have caused tensions to build up within the community, where there are limited resources. As a way of dissipating the possible areas of conflict certain management strategies have been adopted. The tension between the social and administrative reform agendas have been the catalyst that have lead to the adoption of social justice strategies of management. These strategies have increased the emphasis on the rights of the citizen to participate in decisions about them and about how public services are provided. The extent of convergence, divergence, conflict and tension between these different administrative reform agendas is dependent on the politics of those who are leading and implementing them (Yeatman 1990, 3).

Nursing workplaces are now structured in such a way that worker participation is essential. In order to operate at an efficient level, the organisation requires participation and involvement of team members with different skills. This is partly because the work needed to provide health care services requires specialisation. This participation makes it essential for workers to be trained to adopt participatory behaviour,and managed in such a way as to facilitate service provision.

Given the difficulties and uncertainties of the current economic environment it is not easy for workers to move to another position. The almost constant rationalisation of the public sector, with its associated redundancies, job losses, and restructuring, has meant that there are fewer vacant positions available compared to the past, and therefore greater competition for these. Nurses have generally tended to come from the ranks of the working classes and are financially reliant on employment within the

health care industry (Street 1992, 27). Therefore, economic rationalist policies have had a considerable impact on the profession of nursing, and nurses who have secure jobs have considered themselves to be in a privileged position.

The present economic situation has meant that nurses have had to manage with increased workloads and fewer resources. Nurses have also picked up additional workloads when other areas have reduced their services as a cost-cutting exercise. This has had a negative impact on nurse well-being (Napthine 1993, 15-16).

2.4 Nursing environments and the relationship to burnout

Nursing work takes place in a wide range of environments, some of which have working conditions which are more stressful than others. The effect of these different environments on nurses, with regard to burnout, have been studied in detail by clinical psychologists. Although these scholars have suggested ways of addressing the problem of burnout, they have so far not addressed the workplace issues which cause burnout to occur. This is because the clinical psychologists have focused on the individual nurse adapting to the work environment, whereas individual nurses have identified the workplace as the major cause of burnout, that is external factors for which they have little control.

Cherniss (1995) recognises that nurses are affected by their work environments and by their perceptions of that work environment. The impact of the nurses' perceptions of their work environments affects their abilities to withstand burnout. Where nurses understand their work environments to be unsupportive, and they become separated from a sense of belonging, this produces negative stress resulting in

burnout.

Nursing researchers such as Vashon (1987) studied stress related to nurses working in community environments and hospital settings; O'Keefe (1985) studied Intensive Care unit staff; Constable and Russell (1986) looked at hospital settings; Hare et al. (1988) studied staff in nursing homes; Holman (1990) looked at staff in palliative care settings; Åström et al. (1991) studied nurses in geriatric and psychogeriatric units; Oehler et al. (1991) studied staff in neonatal units; and Willis (1991) studied remote area nurses.

Review of this research on different nursing environments found the main issues contributing to burnout to be:

- Underestimation of workplace stress (O'Keefe 1985).
- Low job enhancement related to work pressure, the work being task oriented, unclear instructions, and, a lack of autonomy, innovation, supervisor support and physical comfort (Constable & Russell 1986).
- Low job satisfaction and the emotional climate of the work environment (Humphris & Turner 1989; Hare & Skinner 1990).
- Poor interpersonal and physical relationships (Benjamin & Spector 1990).
- Frequent exposure to death, attitudes equating death with professional failure, a lack of professional education, and poor organisational coping strategies among nurses (Holman 1990).
- Lack of experience, and a perceived lack of supervisor support (Oehler et al.

1991).

- Isolation, subordination and bureaucratic constraints in remote areas (Willis 1991).

- Dealing with an apparently excessive workload (Tyler et al. 1991).

No single cause was identified by any of the researchers, but a number of work issues and personal attributes were seen as influencing the individual's ability to cope in the workplace. These contributing factors related to how staff felt about the work conditions and the support they received. However, the researchers did not address the workplace issues, such as lack of power and authority to address resource issues, which caused the staff to 'burn out'.

2.5 Medical dominance and nurse compliance

Nurses are socialised into behaving in certain ways, in accordance with institutionalised norms and needs. According to Lupton, the hierarchical nature of the health care environment has meant that nurses have had the added strain of being lower in the medical hierarchy, compared to doctors. As a result of this, nurses have had to deal with professional conflicts, and contend with power struggles, sexism and paternalism on the part of patients and doctors and administrators. These inequalities of power are related to gender (doctors have been traditionally male, nurses being traditionally female), social class, and also the nature of their work (doctors are concerned with curing, nurses with nurturing and caring) (Lupton 1994, 121).

The oral culture of nursing often works to dis-empower nurses through their lack of

engagement in written documentation. The value of experience has not been recognised by society as it does not conform to the dominant scientific ideology. The written code of the academic culture of medicine is seen as superior to the oral culture of nursing, and medicine is seen as a science (Street 1992, 19). Nurses remain oppressed by the oral basis of nursing culture because they have so far been hesitant to document their clinical knowledge and practice (Street 1992, 268).

Where nursing knowledge has been documented, it has often merely been an extension of the medical perspective. Hare, et al. (1988) looked at the prediction of burnout in hospitals and nursing homes and concluded that burnout is both a personal and work problem but did not offer nurses any help in addressing the workplace issues.

Humphris and Turner (1989) studied job satisfaction in a unit for the elderly and severely mentally infirm at a time when the unit was moved to another location. All nurses who found the workplace too stressful left their jobs, so the workplace issues that caused the stress were never addressed.

Hare and Skinner (1990) researched burnout at another nursing home and found that it was important to have an environment that enhances self esteem. Where nurse managers addressed the issues of autonomy, task efficiency, and reduced work pressures this had little effect as the staffing levels were inappropriately low. The nurse managers did not have the power to address the real issues in the workplace related to resources.

Turner claims that nurses occupy subordinate positions within health care and have little prestige in the market place. The traditional weakness, characteristic of female labour, is the establishment of a vicious circle, where low job satisfaction results in

broken careers and inadequate career structures, to produce low occupational commitment (Turner 1987, 374-383).

A general perception that is evident in the literature, is that, in the health care industry, nurses are perceived as having limited control over their destiny. Nurses' participation in the health care organisation is limited to the role of service provider, and nurses are seen as having no intrinsic value, outside of the provision of this service. Consequently, when nurses can no longer provide these services, they are seen as having no value and become instead a liability to the organisation.

One of the possible reasons for this, as discussed by Lawler, is the nature of nursing work. Nursing work involves body care and the crises of birth, illness, and death. Body care is concealed and sanitised by nurses because it is seen as dirty work by society. In the process of concealment nurses perpetuate public ignorance, and to some extent become 'victims' of their own work (Lawler 1991, 224). Nurses are thus unable to address the stressful issues related to the nature of their work, publicly, because the work is seen as dirty, and to talk about this work is socially unacceptable. In society, those groups that are involved with socially unacceptable work are seen as socially subservient to those groups performing tasks which have greater social acceptance. Thus, this reinforces the subordination of nurses to other health care professionals.

The body care that is associated with nursing's 'dirty work' is also closely associated with the traditional caring roles assigned to women in society. Turner (1987, 148) discussed the link between nursing care and women.

Nursing is perceived to have a feature quite peculiar to its history, namely its female character. Nursing is an example of the subordination of women to patriarchy

(represented by the medical profession). Exploitation occurs, and is socially justified under the ideologies which assert the naturalness of nursing as a feature of the female personality.

Women are exploited as nurses because they are socialised into a doctrine which equates nursing with mothering and sees the hospital ward as merely an extension of the domestic sphere of labour (Turner 1987, 149).

In addition to this, Oakley suggested that nursing has four characteristic features of the traditional role of the housewife. These are that nursing work:

- is almost exclusively allocated to women, rather than both sexes;
- is associated with economic dependence;
- has the status of non-work, because it is associated with caring, which is not seen as being real work, or economically productive work; and
- is seen as primarily women's work (Oakley 1982, 1).

Thus, nursing work is seen as an extension of the traditional female role. This is supported by Lawler who also links the role of women to the role of nurses within society (Lawler 1991, 224).This further impacts on the nurse suffering burnout by adding additional pressures. This ideology suggests that as the nurse is no longer able to perform her duties, she has not only failed as a nurse, but also as a woman. In addition to this, as nursing is a natural extension of the role of women in society, failure is seen as unnatural, and must relate to a maladjustment of the individual. Although this ideology does not relate directly to male nurses, they are also affected.

According to Cox (1996), male nurses are highly conscious of their masculinity, their physical ability is valued, and they have to be more virile than other males to avoid losing their gender power roles. This helps their working relationship with senior male medical practitioners and they are more likely to be seen as suitable for managerial positions; this is probably because hospital management is primarily male. Therefore, when a male nurse suffers burnout, he has failed not only in adapting to the workplace role, but also in his masculinity.

Male nurses have adapted to a caring role traditionally reserved for women, and when they fail at this, it is seen as a personal failure to care. Society also takes an extreme view towards male nurses who have failed at their job. This is as a consequence of nursing being seen as women's work, and thus regarded as being easy work.

O'Hara (1989) discussed the role of the male nurse in the workplace, which is typically female. Male surgeons cope with their power over male nurses by designating the male nurse to the role of homosexual. The male nurse is reduced to the role of honorary woman by the fallacious equation of male nurse = gay = effeminate = woman (O'Hara 1989, 93). Thus a male nurse suffering burnout has 'failed' in his work and has become an emotional misfit who is shunned by his female colleagues.

Because nurses have been socialised to accept their subservient role, they have been powerless to address the work conditions that have caused burnout to occur. Medical dominance of the health care system has meant that nursing needs have not been seen as a priority, and have thus not been addressed.

2.6 The 'vocabulary of complaint'

Turner (1987, 152) suggested that while there is an ideology of compliance and discipline within the nursing profession, there is also resistance and opposition from nurses to traditional working conditions, bureaucratic regulations, and the notion that nurses are compliant totally with doctors' instructions. There is a split in the occupational culture of nursing into a discourse of compliance and complaint. While the nurse acquires a formal occupational culture as part of her/his training, there is also a socialisation into a sub-cultural occupational ideology. Turner called this alternative occupational ideology the 'vocabulary of complaint'. The official occupational ideology specifies how the principle tasks are to be accomplished, while the vocabulary of complaint outlines methods of survival on the job which have the consequence of de-legitimising the authority of the formal structure of the bureaucracy (Turner 1987).

The 'vocabulary of complaint' serves an important function. The crucial complaint is focused on the experience of lack of autonomy within bureaucratic settings in relation to the patient and health care. Nurses complain about the absence of control over their situation, and sharing these complaints with each other is an important aspect of the informal organisation of nursing as an occupation. Complaints articulate the differences between nursing skills and medical skills, and also highlight the nurse's lack of autonomy within the medical bureaucracies of health. Turner (1987, 377-382) identified five main components that function to express the value and differences of nurses compared to medical practitioners. These are:

1. The vocabulary underlines the independent contribution and importance of nursing to the therapeutic process. Nurses devalue the function and significance

of the doctor in the therapeutic process, providing a negative view of the doctor's role. Patients are seen as in need of protection from male medical intervention, which represents a threat to their health.

2. The vocabulary serves to de-legitimise the system of authority and hierarchy at the place of work.

3. The complaint system deflates the unwarranted idealism of young nurses and seeks to describe the real nature of nursing as a laborious, tiring, and unrewarding set of activities, which is a realistic view of the social role of ward nurses. These complaints see much of the activity on the ward as irrelevant and useless, and merely to support the bureaucratic function of hospitals, rather than to care for the patient.

4. The vocabulary creates a sense of solidarity of the work force against the intrusion and dominance of the bureaucracy and the medical profession. Since the majority of nurses are female, the complaint system operates to unite female nurses against their male superiors. Complaining is therefore a crucial feature of occupational sub-cultures where solidarity becomes an important aspect of resistance.

5. Complaining acts as a safety valve which lets off emotional frustration against the contradictions and tensions of the workplace. Once released in a collective way, the solidarity of the group is reasserted, but the complaining does not necessarily lead to systematic changes in objective conditions. Complaining is symbolic and consists of collective gestures against authority. Despite the nurses' symbolic encroachment on medical authority, the objective situation of nursing is maintained and the powerlessness preserved.

The complaints have the function of uniting nurses as an occupational group sharing a common experience and language. Although the complaints verbally de-legitimise the authority structure with respect to the nurse-doctor relationship, the outcome is conservative.

Much of the research on burnout in nursing, such as that by Donovan (1990), Oehler et al. (1991), and Willis (1991), can be seen in the light of this vocabulary of complaint by underlining the independent contribution and important function of nursing in the therapeutic process, de-legitimising the authority of medicine by creating a sense of solidarity and acting as a safety valve to release emotional frustration. These researchers unite nurses in their suffering, but do not present nurses as a political force who are able to address the issues which affect themselves in the workplace.

2.7 Perceived alternatives to the medical model of dealing with burnout

The medical model of dealing with burnout has failed to address the problem for nurses. The medical focus on the individual has not addressed the workplace issues that caused burnout to occur so burnout has continued to be a problem for nurses. A growing number of nurses have become dissatisfied with the way medicine has dealt with illness and health and challenges have resulted. Illness has been seen, by nurses, as an imbalance between individuals and their environment and this view contrasts with the bio-medical model of disease as an invasion from the external pathogen. The alternative emphasis has been on the individual's life history and the combining of the mental, spiritual and environmental dimensions of well-being. According to Berliner and Salmon many people, dissatisfied with the fragmented, mechanical body

image of bio-medicine, have conceptualised health in a holistic manner emphasising the perception of health as a value in itself, and the individual actively participating in the on-going maintenance of good health (Berliner & Salmon 1980, 143).

The rapid growth of the alternative health industry supports the view that many people have been attracted to new alternative therapies as a way of addressing their health needs. The alternative health industry is strongly associated with the ideology of nature and health. In Coward's (1989) book *The Whole Truth: The myth of alternative health*, 'nature' is described as having a powerful symbolic meaning in late capitalist society, related to virtue, morality, cleanliness, purity, renewal, vigour and goodness. By implication, therefore, the alternative therapies support the ideology of nature as being safe and gentle, and therefore appear to have inherent properties which will benefit individuals.

Critics, such as Otto (1985, 13-15), have argued that the ideology of alternative medicine differs little from that of scientific medicine. Both place emphasis on the individual's responsibility for their health. The rejection of the philosophical beliefs of orthodox medicine by alternative therapies does not offer a political critique of health service practices. Alternative and scientific medicine both fail to address the link between the individual's health and the broader social environment, such as the impact of social class. Alternative therapies, by focusing on the individual, merely serve as another social control mechanism.

Alternative practitioners have attempted to legitimise their practices by introducing standardisation and licensing. This assures a level of knowledge and skills of the practitioners. However, by emphasising the professional aspects they are more likely to approach the doctor-patient model of treatment that prevails in medical behaviour,

where the patient is submissive and the treatment giver dictatorial. The behavioural boundaries between medicine and alternative therapies are becoming blurred and the treatments are merging, as is demonstrated by Powell (1993).

Berliner and Salmon's (1980, 143) view is that many of the practices of alternative therapies for 'personal' problems tend to adjust the individual to the society from which the pathology has arisen. Alternative therapies come from the middle class professional and often these alternative therapy movements have little to offer the lower socio-economic classes of people. Payment for the treatment is not covered by reimbursement from public or private health funds and the costs of the services means that the service is limited to those who can pay. The psychological perspective as presented by Powell (1993) is a model of an alternative therapy, within the behaviour-medical perspective.

In many ways alternative medicine adds to the medicalisation of western culture and further extends jurisdiction over patients' autonomy. The ideology of nursing with its interests in the 'whole person' may also be viewed as extending the medical gaze into the personal lives of patients. This too can be interpreted as an extension of power over the patient. Moral judgments are also emphasised in that the language used by the health care professional serves to position the body as a metaphysical essence, and by doing this judgments are made based on what is bad or good for the body (Montgomery 1991, 355-358).

It can be argued that alternative therapies retain most aspects of the ideology of medicine. Where alternative therapies have been seen as alternatives to the medical model of health, they actually serve as an extension of the medical model, not as an alternative. Notions of health and illness continue to have medicalised functions and

meanings (Crawford 1980, 370). Alternative therapies are no more concerned with practice and procedure than symbolic meaning, and do little to challenge the medical paradigm. They overtly offer an apparent alternative to the medical behavioural model, while they covertly legitimise social inequality (Coward 1989, 42).

Since the 1970s self-help ideologies have become a popular strategy of resistance for those who have become dissatisfied with the medical model of health. This thinking is a part of wider socio-political movements, such as the women's movement. These movements have the potential to foster resistance to victim-blaming ideologies and dependence on the medical profession, by transferring simple medical skills to lay people and constantly highlighting medicine's role in the oppression of women (Crawford 1977, 676; Broom 1991, Chapter 6).

The middle class orientation of the self-help movement does not address the barriers to social change. These movements have continued to direct attention towards expanding the provision of health, rather than addressing the question of the dynamic nature of the discursive constitution of illness and the body (Broom 1991, 148-149). Using Foucauldian perspectives, self-help movements have extended the normalising gaze, but have focused on the judgments of the members of the group, who replace medical professionals, in maintaining surveillance over each other and themselves (Silverman 1987, 230).

Self-help movements are extensions of the medical model and serve to control the 'patient' (the nurse, in the case of burnout) in the medical model using managerial and other discourses to alleviate any areas of possible conflict. Individual nurses do not have the power to change unhealthy workplaces, especially while they are seen as being psychologically maladjusted. Self-help texts are useful in learning skills to

adapt, but why would anyone want to adapt to a workplace that is unhealthy?

2.8 Nursing strategies for dealing with burnout

Review of nursing literature on burnout identified a number of management strategies as a way of dealing with burnout in the workplace. For example:

- Survival tactics, such as identifying the rights and needs of all individuals, and strategies for addressing the physical, social and emotional needs of individuals in the work environment, as well as education about burnout and how to manage it (Branco et al. 1981).

- Reducing stress from a personal perspective and using a change of environment as a possible way of reducing stress and avoiding burnout (Hickey 1985).

- Programs to facilitate coping as a stress management tool (Lewis & McLin 1991).

- Training techniques to improve communication skills (Roger & Nash 1993).

- Programs of burnout prevention by promoting elements of job enhancement, reducing unhealthy work pressure, and increasing social support mechanisms (Constable & Russell 1986).

- Investigation of organisational social support and the use of coping strategies as buffering agents between occupational stress and burnout (McAbee 1991).

- Support groups to help health care workers cope with the stressors they

encounter in their professional and domestic situations (Hiscox 1991).

- Leadership and communications training for supervisors to enable them to provide more appropriate support and encouragement to the staff, as well as implementing changes to overcome high work pressure and low work involvement (Robinson et al. 1991; Simms et al. 1990; Constable & Russell 1986).

On the organisational level, exercise programs, dietary awareness, stop-smoking options, stress management workshops, and psychological services have been proposed to prevent burnout in the workplace (Leighton & Roye 1984; Patrick 1984). These 'encourage workers to cope with subordination, exploitation, and alienation' (Arches 1991, 202). Arches' study looked at social workers, but her comments are equally as relevant to nurses and the environment within which nursing occurs.

Some nurses have attempted to address the problem of burnout from a nursing perspective, however, the language that they have used is that of the dominant group in health, medicine. Texts can be seen as the battlegrounds where social issues, policy disputes, implied meanings, etc., requiring public and political support, are debated, contested, and struggled over. How issues are framed plays an important role in getting the issue defined and influencing the outcome. 'Framing is the process by which advocates convey their message with the intent of maximising the affirmative and minimising the negative values associated with them' (Carey et al. 1994, 26). By using the language of medicine to frame and discuss the problem of burnout, nurses have reinforced the hegemony of medicine, and have ignored the nursing perspective, that is how nurses have perceived the problem which includes the workplace issues.

2.9 Summary

Burnout has been studied in various nursing environments by both nurses and clinical psychologists who have identified several work issues that have had a negative impact on nurses' well-being. Many of these have a direct relationship to the nature of nursing work. However, the nature of nursing is such that, so far, nurses have been unable to address these issues.

In the workplace, nurses have been subordinated to medicine on the levels of knowledge, gender and the nature of the work involved. Medical power has been socially constructed in this way, and nurses have been socially conditioned to accept this subservient role. The subordination of nursing to medicine is not without conflict but this conflict is discursively dissipated through the 'vocabulary of complaint'.

Previous methods used by nurses to address the workplace issues that create problems such as burnout have generally centred around the medical model. They have therefore served merely to reinforce medical dominance.

The literature does not address the problems in the workplace that cause the nurse to become burnt out but focuses on the identification and treatment of burnout. If nurses are to address the problem of burnout them it is important to address the workplace issues that cause the problem in the first instance. To do this, it is important for them to analyse how burnout is socially constructed, and understand the social and cultural nature of nursing.

In the next chapter the methodology used in the analysis of a contemporary book on burnout is explained. The aim of this analysis is to show how burnout is socially

constructed and to expose the ideological dimensions of this construction. A critique of the analysis will encourage nurses to address the stressful public issues that impact on them, and develop strategies to address nurse well-being from a nursing perspective.

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Chapter 3

Discourse analysis

3.1 Overview

The literature review on burnout identified some of the nursing environments in which burnout occurs. This is related to the nature of nursing work, being an extension of women's work and the hierarchical social structure of the health care service.

A number of strategies have been identified to manage the workload and staff more effectively. The treatment of those suffering burnout has followed the medical model, which focuses on the individual adapting her/his psychopathology to accommodate the work place. However, this approach has not addressed the problem of burnout for nurses. This is because the social issues, in the form of workplace problems that cause the individual to suffer burnout, are not addressed.

This chapter describes and justifies discourse analysis as a method of analysis which is used to critique a text on burnout. The text, *Burnout* was written by Ken Powell (1993), a clinical psychologist. The aim of the analysis is to expose the ideological dimensions of the concept burnout, how it is constructed, and how this construction benefits certain groups within society.

By focusing on the social, cultural and political dimensions of the problem of burnout and the effects of this conceptualisation on nurses, it is possible to move the debate beyond the present boundaries and address the problem of burnout for nurses.

3.2 Discourse analysis

Discourse analysis is best described as an interdisciplinary field of inquiry (Lupton 1992). As used in this chapter the terms discourse and discourse analysis will be taken to refer to the recent developments in our understanding of the ways in which individuals and institutions communicate through written texts and spoken communications, focusing specifically on the work of Lupton (1992) and Kress (1985). 'Discourse' is defined as a patterned system of text or communications that are located in social structures. Discourses may be rule-governed and structured, or they may be more ad hoc and context-bound (Lupton 1992).

Through discourses it is possible to identify patterns of words, figures of speech, concepts, values and symbols, and a coherent way of describing and categorising the social and physical world. Discourse analysis is a way of making sense of objects, persons, social groups and events. All discourses are textual and expressed in text, intertextually drawing upon other texts in their discourses to achieve meaning, and contextually embedded in historical, political and cultural settings. Discourses are organised in terms of abstract principles and serve as a means of communicating purpose and strategies to achieve a desired end, generally supporting the interests of the communicators (Lupton 1994, 18).

As a methodology, discourse analysis focuses upon the area of contemporary culture and society, documenting the links between textual and oral communication, and society and social change. Discourse analysis examines the communication processes in their social, political and cultural dimensions, emphasising theory formation. It focuses attention upon the rhetorical devices and linguistic structure, the subject matter, and style of the communication and the manner in which ideology is reproduced. Emphasis is also placed upon how discourses are produced as well as

the reception by audiences. In discourse analysis, the text is examined critically and not just descriptively (Lupton 1992, 145). Discourse analysis reveals not only what is said but the possible motives behind the discourse. Why is the discourse constructed in this way? What does the writer wish to achieve? How does the writer aim to achieve these goals? What discourses are used or referred to?

The socio-cultural experiences of people influence the meaning of the text. Readers have a number of pre-existing discourses available to them. These are determined by their own social location, that is, their social class, occupation, age and gender. First-hand experience, interpersonal interaction and internal processes like logic are resources that readers can use to resist and negotiate textual meanings. Texts are therefore polysemic and capable of having multiple meanings (Lupton 1994, 38).

A critical analysis of a text relies upon the interpretive skills of the researcher for verification. Discourse analysis is not a methodology that relies on scientific method and statistical data to demonstrate the validity and reliability of findings. Interpretation of the text is from the researcher's perspective and as such, is itself subject to interpretation. There may be multiple dominant textual readings according to different social and historical conditions, and according to who is involved. Meanings are not static but change as time goes by. Texts are the sites where the struggle for meaning occurs (Lupton 1994, 28-33).

Texts arise out of specific social situations and are constructed for specific purposes. Meanings find expression in texts, but the origins of those meanings are often outside the text. Conventionalised forms of discussion lead to conventionalised forms of texts called 'genres'. Genres take specific forms and purposes, and examples of genres include essays, interviews, books, sermons and so on (Kress 1985, 18-19). From this perspective Powell's text (Powell 1993) fits within a particular genre, that of the

self-help health care text.

3.3 Process

As a way of understanding the text at a textual and contextual level it is necessary to become immersed in the text. On reading and re-reading the text a number of times the structure that Powell has used in the narrative emerges. Powell has used a number of narratives to construct the phenomenon of burnout, that is burnout is described in a number of ways from a number of different perspectives. The dominant narratives or discourses that Powell has used are those of:

- medicine,
- psychology, and
- economic rationalism.

The discourses serve to position the reader into certain ways of thinking about burnout. They do this through Powell's use of metaphors. It is thus possible to expose the discourse by drawing attention to the types of metaphors used and how the images that are created are used. These are the structural dimensions of how the narrative is constructed at a textual level.

For example, on the back cover the reader is informed that Powell is a 'chartered psychologist' who has spent many years working with organisations and individuals on stress and burnout. Powell is linked by a quote on the back cover from a Dr Mike Smith 'I prescribe this helpful book'. From the outset there is a strong link between

medicine and psychology. Within this text burnout is described in medical terms and is viewed as 'the final response to cumulative, long term negative stress'. To reinforce this perspective Powell refers to the work of other psychologists such as Cherniss (1980), Firth et al. (1987) and Maslach (1976), and also the work of Selye (1974) all respected researchers in the area of stress. There is thus a link between this book and other scholars who are working in this field. This, indirectly, gives this work credibility.

Powell's use of the primary narratives of medicine, psychology and economic rationalism are strengthened by the sub narratives of science and management. These narratives provide key images. For example, in the medical discourse there is an image of illness, and illness needs to be 'cured' and it is up to the individual to seek a cure and to take control of her/his burnout. There is an urgency attached to the medical images of infection and contamination and the need to clean it up. The medical image is linked to psychology with the 'cure' being focused in the realm of behaviour modification. These changes in behaviour are measured scientifically as a way of supporting and justifying this method or cure. Organisationally these methods are linked in economic rationalist terms in the 'need to be effective and efficient'.

Powell's use of client case studies is a very powerful way of positioning the 'audience' into a client role in need of 'treatment'. The treatment of choice is naturally in the form of a medical psychological solution. The way that Powell positions the audience discursively eliminates other possible choices of treatment such as spiritual or organisational changes. The case studies provide a very simple but powerful way for the reader to identify with the symptoms experienced by other nurses early in the text.

Within the text there are two distinct voices: those of Powell, the clinical

psychologist, and those of the nurses, clients, who are suffering from the effects of burnout. Thus the problem of burnout is conceptualised from two perspectives, Powell's and those of the nurse clients.

The text provided a site where Powell tried to resolve particular problems. The problems identified were:

- the nature of burnout;
- stress and burnout;
- the nature of organisations;
- the concept of nursing;
- people with burnout;
- interventions; and
- interpretation .

The analysis of Powell's text served to highlight the dominant groups in society and their agenda when addressing the problem of burnout, but more importantly it exposed why burnout continues to be a problem for nurses.

3.4 Justification

The decision to analyse Powell's text was based on several considerations. Firstly, the case studies presented in the book, in broad terms, resembled case studies

encountered in the author's practice as staff counsellor at a regional hospital. The literature equated to the medical model of burnout, and Powell's approach to the treatment of burnout was similar to the treatment the author's clients had received. Powell's approach to dealing with burnout is characteristic of that employed by a number of clinical psychologists and scholars researching the area of stress. These include psychologists such as Cherniss (1980), Maslach (1976), Pines (1981) and Firth et al. (1987) and the work of Selye (1974).

3.5 Summary

Discourse analysis of a text on burnout is used as a method to analyse and critique how burnout is constructed and treated in contemporary society. Analysis of the text exposes two opposing points of view, those of the nurses in the case studies and Powell, as the treating psychologist.

Within the text Powell provides sites where problems are identified and resolved. The problems identified involve the nature of burnout, stress and burnout, the nature of organisations, the concept of nursing, people with burnout ,interventions and interpretations.

The following chapter addresses the construction of burnout in relation to the clinical psychological perspective and the perspective of the nurses Powell is treating for burnout in relation to the problems identified.

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Chapter 4

The construction of burnout

4.1 Overview

How the concept of burnout is constructed affects how it is dealt with in society. The construction of the phenomenon reflects who has power in society, what groups have power over others and how that power is exercised. Powell has written the book, *Burnout*, with a specific purpose in mind. The explicit purpose is to provide a self-help text, but within that, at a contextual level, Powell as clinical psychologist is providing an account of burnout which is constructed from his clinical perspective. Within the text, Powell strengthens his psychological perspective by aligning himself with two powerful groups in society, medicine and the health bureaucracy.

Powell has used case studies as a way of illustrating his approach to burnout. This serves to discount any debate as to the legitimacy of his approach. According to Kress (1985) authors try to resolve discursive differences within text, positioning the reader where the text seems natural and unproblematic. By constructing burnout from this perspective, the psychological approach of burnout is seen as the most natural way of dealing with burnout, and the people suffering from burnout. From this perspective, as described in the case studies, experiences are due to psychological problems in the clients' personalities. By taking this approach Powell discursively avoids any possible areas of conflict, aligning himself with the powerful medical and bureaucratic perspectives which are the dominant approaches of powerful groups in society and in health. Throughout the text Powell gains both a professional and social advantage over the nurses suffering from burnout. He does this by re-articulating the nurses' perspectives and presenting them as having personality disorders. The work

conditions that the nurses identify as causing their burnout are re-articulated as personality dysfunctions and are therefore not addressed. In spite of Powell's claims of empowerment, the text serves to control and dominate nurses suffering burnout, as nurses are portrayed as unable to address their own work situations. Indirectly this serves to subject all nurses to subservience and dominance to both medicine and the bureaucracy in the workplace.

Generally, self-help books serve to reinforce the medical model of treatment. This book on burnout is an example of this. The author positions the reader by limiting the agenda and although the books are written as if they empower the reader, the agenda is limited by the author eliminating any possible antagonistic positions by prescribing the agenda. Powell's use of nurses in the case studies reinforces professional dominance of medicine over nurses in the workplace. He portrays nurses as victims in need of help in the form of treatment for their personal problems. Organisational problems are marginalised through the use of economic rational ideologies and nursing problems are restructured and addressed as needing medical solutions. This approach subordinates nurses to medical dominance on the level of professionalism, gender and knowledge.

This chapter starts with a general discussion on self-help genre and their effectiveness. It then leads to the analysis of a specific self-help text on burnout, beginning with how the text is constructed and how the author positions the reader. Following this is a discussion of the map of preferred meanings within the text, covering the areas of the nature of burnout,the relationship between stress and burnout, the nature of organisations, the concept of nursing and people with burnout and finally the interventions.

4.2 Self-help genre

On a superficial level, self-help texts might appear to have been written as a way of allowing individuals to take more control over their own lives. For example on the back cover of Powell's book it says: 'This book offers practical ways to deal with immediate problems as well as solutions to tackling the underlying issues. It will help you take the heat out of extreme stress - and regain control of your life' (Powell 1993, cover).

However, assumptions regarding the facilitation of self-empowerment have been challenged by scholars such as R.D. Rosen (1977) and G.M. Rosen (1987). For instance, R.D. Rosen (1977) has argued that typically texts falling within this genre are dominated by what is referred to as 'psychobabble'. By this he means the fashionable but hopelessly vague language used in many of these books. Such books, R.D.Rosen (1977) suggested, focus on the individual gaining more happiness by using the information contained within. However, the meanings in the text are often obscure and unintelligible, and often sacrifice clarity in favour of jargon. Frequently, then, the effect is to prevent rather than enhance effective communication (Weiten et al. 1991, 8).

Within the self-help text, scientific soundness is often absent, and there is no scientific research offered as a basis for theory. Frequently ideas are based on the author's intuitive analysis which may be highly speculative, but not necessarily presented as such. Even when more responsible authors provide scientifically valid advice and are careful not to mislead their readers, publishers often make outrageous and irresponsible promises on book covers (Rosen, G.M. 1987). An example of this is the cover of Powell's book where readers are promised a way to regain their sanity.

Another shortcoming is that self-help books do not usually provide explicit directions on exactly how to change behaviour. The tone of these books is usually very humane, but 'unfortunately, when the book focuses on how to deal with the problem, it usually provides only a vague distillation of simple common sense, which often could be covered in two rather than two hundred pages. These books often fall back on inspirational cheerleading in the absence of sound, explicit advice (Weiten et al. 1991, 9).

Texts falling within this type of genre tend to encourage a self-centred approach to life that does not take into consideration the consequences of any action. This model of behaviour focuses on self-determined ethics and is an exploitative approach to interpersonal relationships (Weiten et al. 1991, 9).

4.3 The construction of the book

Powell has constructed the book in six chapters. Chapter 1 is a basic description of 'the world of burnout' which is a broad description of how burnout is perceived in the broad social context.In chapter 2 Powell focuses on the individual's perception, that is 'burnout from within'. This chapter includes case studies of people who have suffered burnout. Chapters 3, 4, 5 focus on ways of dealing with burnout. Chapter 6 is the conclusion. As an appendix there is a list of 'useful addresses'. Overall the book presents a contemporary view of burnout which is aimed at providing individuals with support so that they can 'control' their stress and 'regain their sanity' (Powell 1993, back cover).

Powell's book is based on a series of case studies of predominantly nurses and

teachers and social workers. His perspective supports a medical approach to dealing with the problem of burnout. Nurses and teachers work mostly within organisations and Powell strengthens his approach by linking it to the bureaucratic approach through the use of organisational flow charts (Powell 1993, 43) and figures (Powell 1993, 51). He describes the organisation in which nurses work in medical terminology. For example, it is the individual's responsibility to 'relieve the symptoms' of her/his stress (Powell 1993, 41), and to assess the organisation's qualities as to whether it is a 'healthy organisation' (Powell 1993, 44) and to remove yourself from a 'contaminated' organisation (Powell 1993, 48). The focus is on the individual taking control of the situation 'You owe yourself a commitment'; 'you need to decide to get out' (Powell 1993, 51).

Powell positions the reader, who is presumably someone trying to control stress and burnout, into making a decision about his/her work and his/her workplace. He focuses on the individual taking responsibility for her/himself, work and workplace. For example, 'you are more use to your organisation if you are mentally and physically fit. Your family will also appreciate you more' (Powell 1993, 66). These metaphors assume that the person has control over the work situation and only has to exert that control to alleviate stress. Flowing on from this Powell goes on to offer 'techniques that help' (Powell 1993, 88). These techniques all fall into the realm of psychology and behaviour modification. Thus the reader is positioned into choosing techniques that fall within the medical psychology perspective. If these techniques do not work Powell proposes that it is 'helpful to take a deeper look at yourself to see what is behind the stress in your life' (Powell 1993, 101). To do this Powell proposes 'Personal Construct Psychology' which uses a scientific perspective to measure personal constructs.

If this does not work Powell guides the reader through a chapter on how to explore new career paths. This exploration is supported with sample scientific working grids on pages 161 and 162. This methodology supports the scientific medical model. Finally, in the Afterword, Powell again forges the link back to the individual needing to 'take control' and 'find a way out of burnout' (Powell 1993, 169) focusing the responsibility on the individual to control her/his burnout.

In the text Powell does not cite the work of other researchers, but he does provide 'references' at the end of each chapter which include reputable researcher journal articles in the field of stress. He aligns himself with the authors of this work by including a reference to his *Repertory Grid Technique Workbook* at the end of Chapter 5 (Powell 1993, 138). Thus Powell's self-help book is aligned with scientific research without the necessary scientific rigour.

4.4 Preferred meanings

Kress (1985) has argued that texts are manifestations of discourses and are the sites where the authors of text try to resolve particular problems. In the case of Powell's text, these problems arise out of contradictions between the way in which Powell represents burnout and the representations preferred by the nurses in his case studies.

The map of preferred meanings covers the areas of:

- the nature of burnout,
- the relationship of stress to burnout,

- the nature of organisation, and
- the concept of nursing and people with burnout.

Table 4.1 is a map of preferred meanings pertaining to burnout as presented by both Powell and the nurses in Powell's case studies.

Table 4.1 A comparison of how the nurses in the case studies see the problem of burnout, and how Powell interprets and re-articulates these meanings

Concept	Nurses' frames	Powell's frames
1. The nature of burnout	Burnout is the result of work overload. (Powell 1993, 23,25,28,29)	Burnout is the result of psychological defects. (9)
	Burnout is external to the individual. (25, 26, 29)	Burnout is internal to the individual. (10)
	Burnout could be prevented by the support of managers. (26, 27, 29)	Burnout can be prevented by personal reconstruction, and management of stress. (52,54)
	Nurses enjoy their work, are flexible and able to coordinate and adapt, and are able to recognise stress. (24, 26)	Nursing attracts people who have personality deficiencies like over-conscientiousness, perfectionism, over-dependency, and low self-esteem. (22)
		Nurses are set in their ways, become obsessed with their work, are inflexible, and are unable to recognise their own stress. (66, 82-84)
2. Stress and burnout	Increased workloads with no support from peers or supervisors leads to burnout. (23, 24, 26-29)	Negative stress which is uncontrolled leads to burnout. (13-15, 17, 40)

Table 4.1 (continued) A comparison of how the nurses in the case studies see the problem of burnout, and how Powell interprets and re-articulates these meanings

Concept	Nurses' frames	Powell's frames
3. The nature of organisations	Nursing administration is uncaring, only interested in the budget, bureaucratic and unsympathetic. (25, 29)	Health is an industry and subject to economic rationalism. (45, 63, 64)
	Hospitals are about providing care; efficiency is to be able to produce a quality service. (24, 26)	Administration is there to ensure that care is available and effective. (44, 63, 64)
4. Concept of nursing	Nurses are caring supportive people, well-educated and able to understand when stress is too much. (23, 25, 27, 28)	Nurses are emotional, unable to see the need to change. They cannot control themselves and are unable to address their stress needs. (21, 50)
	Job satisfaction is an important part of work. (23-29)	Nursing is a job that needs doing. (21, 64, 67)
5. People with burnout	Nurses who are dedicated, hard-working, and have too heavy a load, suffer burnout. (10)	Burnt out nurses have psychopathological conditions. (24, 25, 28, 29, 64, 82, 84)
	Nurses who try to do too much become victims to the system. (23-25, 27-29)	If a nurse cannot cope with the system, then she must either change or leave. (62, 67)
	Nurses are worthwhile people. (25, 27-29)	Nurses are the victims of their own inefficiencies. (82-84)
	Nurses with burnout need support to address their workplace issues. (23-30)	Nurses need support and treatment for their psychopathology. (24, 25)

4.4.1 The nature of burnout

The cause of burnout, according to Powell (1993, 22), is related to the individuals being unable to cope because of psychopathological problems such as:

- a tendency toward depression,
- obsessive-compulsive traits,
- over-conscientiousness,
- a tendency to over-identify with clients/patients,
- perfectionism,
- a low self-esteem,
- over-dependency, and
- idealism (which has turned to disillusionment).

In contrast, the burnout sufferers identify the following issues as causing their problems (Powell 1993, 23):

- taking on extra responsibilities,
- being depressive by nature,
- work overload,
- conflict at work,
- caring for people who need special attention (e.g. the terminally ill, the elderly,

deprived families, etc.),

- inadequate resources,
- inadequate training,
- responding to crises rather than trying to prevent them before they arise,
- feeling isolated and cut off,
- a lack of competence,
- a series of negative events,
- becoming disillusioned after entering the profession for idealistic reasons,
- a lack of peer group support,
- poor supervision,
- isolated management, and/or
- dealing with difficult issues (such as child abuse).

A number of these nursing perceptions are similar to those of Powell; what is significantly different is the perceived locus of control. Powell focuses on an internal locus of control, whereas the nurses focus on an external locus of control.

The nurses in Powell's case studies (Powell 1993, 23-30) are used to describe their experiences in the workplace, especially the ways in which these have resulted in burnout. Powell, the clinical psychologist, then re-articulates the experiences of the

nurses from the perspective of a clinical encounter between a clinician (i.e. Powell) and a client (i.e. the nurses). The nurses represented burnout in relation to experiences they had encountered in the workplace, Powell reframes these representations, approaching the problem of burnout as a form of individual pathology. He does this by labelling the individual nurse as suffering a personality maladjustment disorder, for example 'clinical depression' (Powell 1993, 23) which previously compromised individual stress control.

4.4.2 Stress and burnout

Powell sees burnout as the result of the individuals' psychological maladjustment to the workplace. This maladjustment results in the nurse being unable to cope with the reality of the work environment, and the associated stress. Consequently the solution is for the nurse to either learn to adapt and control the stress, or leave.

However, the nurses in Powell's case studies, view burnout as the result of structural problems such as work overload and hostile work conditions. The strong implication of this is that nurses should be supported, and that those work issues causing problems must be addressed in order to address the problem of burnout.

Table 4.2 identifies the nurses' experiences as presented in the case studies and the structural problems that caused these experiences that resulted in them suffering burnout in the workplace.

Table 4.2 The experiences of nurses in the case studies and the structural problems they perceived resulted in their burnout

The nurses identified experiences such as:	Structural problems that resulted in burnout:
Being unable to help themselves. (Powell 1993, 23)	Trying to cope with workloads that were unmanageable given resource limitations.
Suffering clinical depression caused by pressures at work. (24)	Working in clinical settings which involved caring for confused and often violent patients for long periods of time with little relief and inadequate resources.
Suffering from harassment. (24)	Forced to take sick leave when work problems were unresolved. The nurse was subjected to harassment for taking sick leave.
Physical and mental exhaustion from work overload; being in a no-win situation. (25)	Workload structured without adequate resources for clinical needs.
Enduring unnecessary and stressful administrative and non-nursing time-consuming chores. (27)	Workplace was restructured with increased administrative workload without increased staffing ratio.
Having to put up with attitudes of management who were unprofessional, inflexible and unreasonable. (27)	Workplace was structured in such a way that there was no support to address workplace issues.
Uncaring inhumane treatment of staff by management; working isolation with no supervision or support. (29)	The organisation was structured so that problems with unrealistic deadlines in were not resolved.
Coping with low-level job satisfaction, poor communication and out-of-control lifestyles. (30)	Poor supervision and poor communication with a bureaucratic organisation.

4.4.3 The nature of organisations

Powell views the nurses who are suffering from the effects of burnout as not being able to adapt to reality, that is, a work situation increasingly subjected to the harsh realities of market-driven economies.

> Organisations cannot always be friendly, pleasant places in which to work. Tough decisions may have to be made (Powell 1993, 48); and
>
> If things are unlikely to change and you feel that you are unable to influence them in any significant way; then decide to get out (Powell 1993, 62).

Nurses suffering burnout are seen as being unable to meet workplace demands because of personal deficiencies and need to adapt or leave.

Powell's use of the case studies serves to unite nurses suffering from burnout in their suffering. By positioning the nurses in the client role Powell de-powers them of any control they may have over their workplace situation. Once the nurse is in the client role it is possible for Powell to take control and diagnose the nurses' symptoms as personality dysfunctions, not a normal reaction to an abnormal situation. Powell, is thus able to change the focus of the cause of the problem from external to the nurse to, internal to the nurse. For example in the first case study the nurse says 'I was unable to help myself or even see my problem'.This nurse had identified her problem as due to increased workload in the sentence before. Once the nurse became a client of Powell's her problem took on a psychological dimension it did not have before. Powell re-articulated the problem as being a result of the individual not being able to address her/his own stress and in need of 'help'.Such help is provided in the form of a psychological solution.

Within the case studies, the nurses' discourse provides an image of how hospitals should be, that is, hospitals are caring institutions that are morally responsible for the

welfare of both the nurses and the patients. The nurses in the case studies view the organisations in which they work as needing to provide care for patients, whose needs may vary according to their health. The nurses' definition of quality relates to being able to provide care to the patients already there. The image that Powell presents differs greatly in that the industrial definition of quality is related to the number of services provided. Hospitals are about providing care, and efficiency is about being able to produce a quality service (Powell 1993, 24-26).

These images are at odds, but possible areas of conflict are discursively addressed by Powell focusing on the individual. Either the individual has made an unhealthy choice of work, or there is a problem with the individual being unable to adapt to the reality of the workplace and needs help in adapting. There is no mention of another possible solution , such as political action or addressing the need for adequate resources ,to enable the nurses to provide care to their patients. Powell's approach reinforces the nursing administration position of subservience and inadequacy in providing adequate resources. Nursing managers are thus perceived by other nurses as unable to address nursing needs, bureaucratic, unsympathetic and uncaring, and only interested in balancing the budget, to the detriment of nurses' well-being. This serves to divide nurses and positions the client nurse in isolation. Nurses are portrayed as weak, and unable to address their needs in the workplace. The only option for the nurse suffering burnout is to take Powell's 'proven' psychological solutions.

The nurses in the case studies see the problem of burnout as arising from the 'fact' that their physical and environmental needs, and those of their patients, are not being met by the organisation. The problems associated with nursing administration are re-articulated by Powell as the individual nurse's inadequacy in the ability to chose a healthy organisation to meet their psychological needs.

4.4.4 The concept of nursing

The nurses in the case studies see themselves as leading busy, flexible, practical lives, being well-educated and experienced, hard working, and able to manage their own needs. However, they are working in situations that are not healthy, where there are limited resources, uncaring management, increased workloads and unsafe work practices. The nurses portray nursing as a caring profession that is strongly linked to 'feminine caring' and to women being nurturers. The nurses' expectation of their work environment is that it should reflect nursing values such as altruism, caring, gentleness, nurturing and empathy, and there is an implicit expectation, by these nurses, that they in turn will be cared for by their colleagues and managers.

Powell, on the other hand, is of the opinion that the profession of nursing attracts people with idealistic beliefs which do not fit reality (Powell 1993, 21-23). Nursing work is seen to attract people who are idealistic and over-sensitive, and their training reinforces a public image which does not correspond to the reality of the workplace (Powell 1993, 59 & 70).

4.4.5 People with burnout

The nurses in the case studies view people suffering burnout as nurses who are dedicated and hard working. Burnout is the result of the nurse having too heavy a workload and management's inability to get adequate resources to meet the nursing needs. The nurse becomes burnt out because the clients' nursing needs are not met by resources. The individual nurse tries harder and harder to meet the patients' needs.

The nurse who tries to do too much becomes a victim of the system. Nurses are seen as worthwhile people who deserve support to address workplace issues, and adequate resources to enable them to provide nursing care to their patients.

Powell on the other hand has the view that the people who suffer burnout have psychological conditions and are in need of psychological treatment to address their inadequacies. A nurse who is unable to cope with the workplace demands has the choice of leaving or learning to cope with the system. Nurses who suffer burnout are victims of their own inefficiencies and need psychological treatment to address their inadequacies.

4.5 Interventions

Table 4.3 maps out the preferred interventions of the nurses in the case studies and those of Powell. The nurses' view is that they need support and care from their colleagues and managers . Workplaces need to be structured in such a way that the needs of nurses are addressed. Work loads that are unrealistic need to be redefined and adequately resourced. Nurses who have suffered as a result of workloads that have been too heavy need to be supported by their organisations and work colleagues.

Powell on the other hand maps interventions in the form of psychological treatment. Nurses who suffer burnout need treatment for their psychopathology. From his perspective, managers are there to manage the workplace, not pamper nurses who cannot cope with the workload. Workloads need to be managed efficiently and effectively and nurses need to adapt to these workloads or get out. Burnt-out nurses

need to reassess their suitability for nursing work and either adjust, by using psychological methods, of leave the workplace. Nurses only have worth while they are of use to their organisation as efficient effective workers. Workplaces are not able to tolerate inefficiency or nurses unable to cope with the workload.

Table 4.3 A comparison of how the nurses in the case studies see the concept of interventions to address the problem of burnout, and how Powell interprets and re-articulates these meanings

Nurses' frames	Powell's frames
Nurses need support and caring from their colleagues and managers. (25, 27-29)	Nurses need treatment for their problems. (Chapters 4 & 5)
Workplaces need to be restructured to support nurses. (25, 27, 29)	Managers are there to manage not pamper nurses who cannot cope. (48, 54, 59)
Workloads are unrealistic and need to be redefined. (26-29)	Workloads need to be managed properly. (63-71)
	Nurses need to adapt to their work and workloads. (Chapter 4)
Burnt out nurses need understanding. (24-29)	Burnt out nurses need to reassess their suitability, change or leave. (151)
Nurses are worthwhile people, and need to be supported within the organisation. (24, 26, 27, 29)	Nurses are worthwhile only when they are of use to the organisation. (63)

Within the text is a view of how things should be, which is reflected by the ideology of economic rationalism. According to Barker (1991) economic rationalism can be defined as a commitment to a number of mutual reinforcing beliefs, the main ones being the concept of freedom, limited government, free market economic organisation, and individual freedom and choice with a minimum of coercion from government, private markets being the institutional arrangements to ensure this. This approach defines the world in economic abstract, deductive terms and uses rule-like models. Knowledge generated tends to be specialised, positivist in character, and is theory producing. This ideology then provides a framework to understanding the problems of the world. The whole approach to understanding the economy and society is theory-driven. From an economic rationalist perspective, a good society should provide maximum space for private markets and individual choice. The theoretical apparatus of modern economics is the method supporting these normative ends (Orchard 1992).

4.6 Summary

The text on burnout is constructed from the perspective of a clinical psychologist whose aim is to provide help for people suffering burnout. Within the text is a debate on how burnout is perceived, from the perspective of the client,that is a person suffering burnout, and from the person treating people suffering burnout. Powell strengthens his position by aligning himself with two powerful groups in society namely medicine and management. Although the nurses identify the work issues that caused them to burnout, in the case studies, Powell uses the nursing knowledge and re-articulates it in such a way that it reinforces his perspective as the person who has the knowledge power to address the nurses problems.

Powell controls the agenda and discursively positions the nurses into the subservient role, that of client in need of psychological treatment, avoiding possible areas of conflict related to the unequal distribution of resource in the workplace.

The next chapter focuses on the interpretation of Powell's text. How different discourses compete for meaning, and how burnout is conceptualised as a personal problem, as rather than a public issue.

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Chapter 5

Interpretation

5.1 Overview

This chapter focuses on the interpretation of Powell's text, from social, political and cultural perspectives and the effect this approach may have on the audience, (that is, nurses suffering from burnout).

An interpretation of Powell's text exposes the discourses that Powell has employed in the construction of the problem of burnout, and his solution. The discourses are different, and have different agendas but Powell avoids any possible conflict by discursively setting the agenda, to that of a self-help text. He uses a number of ideologies to do this, positioning the reader in such a way that his way of dealing with the problem is seen as the most natural way of dealing with burnout (Kress 1985).

Within the text the nurses are defined as 'victims of burnout'. Using the victim ideology, Powell provides the obviously natural solution to their problem (Wolf 1993). The nurses are given a 'choice' of the service, but that choice is controlled by the provider of the goods and services (Grace 1991).

The main discourses employed in the text are managerial, medical-psychological and socio-political which are all underpinned by an economic rationalist ideology. The debate on whether burnout is a public issue or personal trouble is ignored by Powell and the public issue, or workplace conditions, that were identified by the nurses as causing their burnout are re-articulated as personal troubles.

Nurses become victims to burnout by 'sacrificing' themselves (Powell 1993, 21, 50, 62, and 69) and the individual needs to 'find the way' out of burnout (Powell 1993, 100). From Powell's perspective the reason nurses suffer from burnout is that they are unable to identify their needs and address them. The individual 'sacrifices' him/herself. This suggests that the individual knows what he/she is doing and chooses to take the action and is in control of his/her environment. This focus of blaming the victim for his/her actions negates the responsibility of those causing the problem that resulted in the nurse having to take the action. It suggests that the nurse's who sacrifice themselves are to blame for their situation.

5.2. Powell's position

Powell has placed himself in a very powerful position as the 'one who knows' the way out of the situation. All the nurses have to do is follow his psychological evaluation and chose the way out of burnout. This image is powerful and serves to differentiate between those that have 'found' the way and those who have chosen to 'sacrifice' themselves.

As already mentioned in chapter 4,4.2 self-help books have the tendency to over simplify solutions and this book does just that. Powell's solutions are discussed in scientific jargon, and illustrated with scientific grids which serve to limit the possible solutions and guide the reader into seeing Powell's solution as natural and obviously the best. However, it also makes it very difficult for those who do not take Powell's solutions, for they are choosing to suffer burnout.

5.3 The nurse client position

Through the use of case studies, Powell positions the reader, who may identify with the symptoms, into the position of his client. There is no debate as to why the experiences happened or other possible solution in the workplace that could be tried to alleviate the stress. Nursing knowledge about the causes of the stress is not explored or valued, instead, the case studies serve to illustrate how powerless nurses are in the workplace. Powell presents an image of nursing knowledge being subordinate to medical/ psychological knowledge. This is because medical/psychological knowledge has a scientific base whereas nursing knowledge is based on experience.

Nursing knowledge is seen as economically less valuable than medical knowledge. This is illustrated in the case study of the ulcer specialist nurse, who was unable to obtain the necessary supplies for her patients because of budgetary cuts (Powell 1993, 25-27). This is in spite of her care being cost effective. The dominant groups within society saw the distribution of resources as needing to go to the medically dominant services as opposed to the nursing services.

Organisations are seen to 'exist to fulfil a mission'. If nurses believe that it is their duty to stay in unfulfilled jobs then 'our view of our problem becomes a self-fulfilling prophecy' (Powell 1993, 103). Powell's message is that the individual needs to find his/her own way out: 'you do not need to remain a victim of burnout' (Powell 1993, 107). This reasoning positions the nurse with no real option other than to leave her job and seek employment elsewhere. If the nurse does not find his/her way out of the situation it becomes the nurse's fault, in that he/she are choosing to be a victim in the free market economy. Thus, by individualising the problem of burnout, social issues are discursively neutralised.

5.4 Major themes

Clear themes such as providing service, planning and control emerge from the text. The first theme, of the author providing a service for the nurses, which is naturally and obviously what nurses need to cope with burnout. The second theme is one of medical dominance, where the nurse is ideologically reconstructed as the client of the psychologist. This theme involves a managerial approach of planning and controlling what is given, and how it is given. Both themes are discursively constructed so as to neutralise possible contending or oppositional discourses,such as those between nursing and medicine, and nursing and management.

The second theme implies control of the nurse over work-related stress. To obtain that control the nurse is discursively positioned into accepting the service provider's plan of service. It is the desire to provide this service, that apparently drives Powell's production of the text. There is however, a conflict between Powell's apparent desire to help the nurse regain control, and what the book actually does. On one hand Powell is saying the objective of the discourse is one of helping the nurse to regain control, but simultaneously he is maintaining a position of power and control as the treatment prescriber.

Throughout the book Powell focuses on the individual needing to take control of his/her life. For example, you need to 'take control', 'take action', 'you cannot rely on anyone else to help - only yourself', 'you need to reduce the risk' (Powell 1993, 40). 'Review your work', however the nurses in the case studies had all tried to address their problems but the problems were related to structural changes such as resource allocation, staff numbers and support. These issues are only addressed

where work is seen as valuable and deserving of resources. The work that nurses do is often not seen as valuable by those in control of resources. Powell's perspective highlights just how little control nurses have over health resources in spite of there being more nurses than any other health professionals.

Powell sees nurses as needing to adapt to their situation in the workplace by changing their perceptions and controlling their stress. Control is implied in 'them' and 'their' needs, wishes, wants, and desires which precedes the provision of service. This implies that the control is with the individual and that their plan or vision determines the course of action for that work and how they cope with the situation. However in the case of nurses, their plans and hopes are reliant on their relationship with other health professionals and often nursing issues are not addressed because the resources are redistributed to other areas. For example, Napthine (1993) identified that nurses have picked up the extra work when non-nursing areas reduced services, without extra nursing resources being allocated to cover the extra workload.

By focusing on the individual 'taking control' of his/her own life, Powell shifts any responsibility that the organisation has to its employees. Although Powell does recognise that the environment is stressful, it is always the individual that has to adapt. By reframing the situation and diverting attention from social and economic inequalities, these issues are discursively neutralised.

Powell claims that his book is to be used to empower the individual, but the self-help genre implicit in the book reinforces the control of other groups (such as psychologists and doctors) over nurses. He is making several broad assumptions, primarily that the nurses have lost control, and also that his treatment will enable them to regain that control.

5.5 Health care organisations as industries

Within the text, Powell uses managerial discourse to frame health care organisations as industries. He outlines the structural features of organisations and claims that they do not exist to be friendly or nice, but to fulfil a mission (Powell 1993, 63) . Organisations are justified in making these decisions because of economics. Powell uses an economic rationalist narrative at the textual level of the text, but also uses a managerial sub narrative to present images of order and control in organisations. Where there may be possible conflict between the needs of the organisation and those of the individual Powell focuses on the organisation's needs as being more important;'you may need to leave to survive' (Powell 1993, 48). Powell discursively avoids the political issues of limited resources being available to nurses, and the fact that the needs of certain groups are not being addressed by justifying the situation with economic rationalist ideology. He thus re-articulates unaddressed needs as the individual's inability to cope. 'Hospitals are for the sick 'and 'Being employed in a business that has to compete in increasingly tough economic conditions means coping with cost-cutting exercises, facing redundancy and job insecurity' (Powell 1993, 63-64).

5.6 Powell's solution to the problem of not coping

To deal with the problem of the individual not coping, Powell offers behaviour modification techniques and education, to help the individual to cope. The skills that the individual needs, as defined by Powell, can also be seen as a way of increasing the

effectiveness and efficiency of the organisation. The organisation's need for efficiency and effectiveness is the link between the managerial discourse and the economic rationalism. By controlling or managing the individual to adapt to or leave the workplace, the status quo is maintained. Those that adapt serve to reinforce the managerial ideology, and those that do not agree with management are encouraged to leave, thereby reducing their stress (or at least removing them from the workplace). According to Powell, organisations are justified in their actions because of their need to provide a service. 'Organizations do not exist to be friendly, kind or nice. They exist to fulfil a mission' (Powell 1993, 63). Workers providing that service need to concentrate their energy on becoming more effective (Powell 1993, 64), instead of becoming politically active and addressing the social issues in the workplace.

In the case studies the nurses all comment on their experience and training but Powell does not see this as important or of value instead he sees that as a reasonable solution to coping with workplace stress is to leave that situation. This serves to reinforce the nurse's inability to cope, and his/her powerlessness. It also serves as an model to other nurses, if they dare to complain, then they too will suffer the same fate. It is difficult to imagine Powell saying to a surgeon, suffering from work related stress, that he should leave his profession and take a lesser paying job. The nurses, however are encouraged to take a job in a less stressful area. For one of the nurses in the case studies this action did not address her stress. In spite of moving to another area, she was faced with inadequate resources and seemingly uncaring nursing administration (Powell 1993, 24). This nurse became a victim once more to the workplace conditions, reinforcing this nurse's powerless position in the health industry. Through the discourse, within the text, Powell divides nurses into those that cope and those that do not. This prevents nurses from uniting and taking political action to address the workplace issues regarding inadequate resources and support.

5.7 The ideology of planning, changing and controlling

> The nature of some work is not easy for those doing it: hospitals are for the sick, coal mines for extracting coal, hospices deal with the dying. If you work in a hospital emergency casualty unit you have to handle horrific injuries. Being employed in a business that has to compete in increasingly tough economic conditions means coping with cost-cutting exercises, facing redundancy and job insecurity (Powell 1993, 63).

In this passage Powell clearly states how he views the work areas of the nurse clients. 'Hospitals are for the sick', and are businesses that must compete in increasingly tough economic times. Two contradicting positions are evident within this discourse; one of providing and serving, and one of changing and controlling. These two apparently contradictory positions are reconciled, often inadequately, by assuming the prior construction of the subject as a client. The client is constructed as an individual with needs, wishes and desires. He/she has the freedom to choose, is a decision maker and a private individual. The service provider describes and displays the goods and services, and the individual client is free to resist persuasion and make up his/her own mind. There is no coercion as the marketplace is free, and the service provider displays the goods (Grace 1991, 339). This discourse operates within the political framework of neo-liberalism.

Where the needs of the individual do not coincide with those of the organisation, the organisation's needs are seen as of greater importance. Thus when the individual's needs are in conflict with those of the organisation, the individual has two choices - to adapt, or to leave. This is demonstrated, by Powell, in his use of a mini personality test as a way of deciding on a career (Powell 1993, 151). At this point, the nurse had already chosen a career, her problem was not related to this career but to the work conditions that she had been forced to endure. The nurse identified what was causing her stress, but was powerless to change workplace conditions. Instead

she was forced to change her perception, or leave her position.

5.8 Managerial discourse

Within the text, areas of possible antagonism are re-articulated as areas of need, on behalf of the organisation. The organisation needs nurses to be involved in participatory decision-making in areas where they have special skills or expertise. This is essential for the efficient running of the organisation in accordance with contemporary management methods. As Grace explained:

> The prevalence of management discourse and its link with marketing reveals a structural form that provides a basis for explaining the relationship between the two themes identified within the discourse. To "manage" in the interests of people's "needs" for the purpose of "efficiency" is a discourse that masks the ideology of marketing and couches it in an "empowering" frame of reference (Grace 1991, 339).

The nature of the health care system is that it requires participatory decision making. Professionals working within the occupational divisions are different and specialised. Potential power struggles are dissipated by the management of 'needs' in an efficient and effective way. Participation is encouraged by the ideology of empowerment. Professionals are empowered to take part in the decision making process but are controlled by the market economy which supports the interests of the dominant groups in society (as already discussed in the example of the ulcer specialist nurse). As Kress (1985) described, the tendency of discourses is to bridge, cover over, and eliminate tensions, contradictions, etc. in texts as a way of addressing ambiguities in cultures. This process is an ideological perspective that has power implications.

Thus, that particular form of political struggle that depends on a clear distinction of roles within a hierarchical system, and associated power to decide and determine, becomes dissipated. By re-defining the agenda in managerial discourse a more

effective work force can be articulated. Dissension is redefined as inefficient and individuals are controlled (or managed) under the guise of becoming more efficient, and thus more effective.

For example in the 'Afterword' Powell states that:

> By taking the advice of this book which you feel is of help to you and putting it into practice, *you will gain a vital edge: control* (Powell 1993, 169) (emphasis added).

However, in reality, nurses suffering burnout give up control over their work and their well-being and have to either adjust to conditions in the workplace or 'choose' a different area to work in. At no time are they in a position of power. They submit to the medical gaze because they have no alternative - there is no where else to go once you are unable to work due to stress. The only legitimate way of dealing with that stress is through the process of becoming a client of a medically dominant service provider. Once the nurse submits he/she is no longer in an empowered position, and in the workplace they are perceived as a victim and are disposable. This has a powerful effect on other nurses as it silences them into accepting conditions that are detrimental to their own well-being, no-one wants to be associated with nurses who are unable to cope, except perhaps in the role of service provider.

For example, within the text, Powell (1993, 20), identifies and offers advice on a number of organisational needs that nurses working in a healthy organisation can expect. These needs all fall within the scope of services that he provides and include:

1. **Training that helps them.** Powell is not a nurse but is able to make comment on another profession's training. The possibility of conflict is hidden behind the 'need to help'. Nurses are seen as unable to address their own training needs.

2. **Counselling or other help to enable them to work through problems.** Here problems in the workplace are defined as personal problems, and the individual needs to change to adapt. Thus workplace issues are re-articulated as personal problems.

3. **Adequate resources.** Powell does not specify what adequate resources are. However, for the nurses, adequate resources, such as adequate staffing and safe workplaces, are needed so that they can do their jobs. For Powell the organisation provides resources which the nurses must manage efficiently. The management discourse has an implicit power perspective and the nurses have to submit to the organisation's control.

4. **Competent and sympathetic supervision.** For Powell competent and sympathetic supervision is managed by a managerial agenda. The nurses view good supervision as supportive and understanding of the needs of both the nurses and the patients.

5. **Efficient, not bureaucratic procedures to work within.** For Powell, efficiency is to effectively manage within a market economy. However, for the nurses, efficiency centres on providing a service based on patient and staff needs.

6. **Clearly prescribed roles, authority and boundaries.** This is management rhetoric which controls staff. The nurses viewed this control as negative and dis-empowering. The social structure of nursing is hierarchical, but this structure is part of a dominant structure of medicine. Control and dominance are sub-discourses of order and this is used to legitimise the managerial agenda. For Powell control is essential for the system to work efficiently.

7. **A share in decision making.** This rhetoric reinforces the ideology of management in an economic rationalist economy. If nurses are involved in decision making then it is nurses who are controlling nurses, and any problems related to the distribution of resources are due to the nursing managers' poor abilities. This management discourse dis-empowers those who complain for they are seen as suffering from personal problems, not suffering from workplace issues.

8. **Constructive appraisals, feedback and positive assistance to overcome deficiencies.** Management discourse encourages feedback to overcome inefficiencies, but nevertheless, justifies decisions to reduce resources as being necessary because of economic restraints. Workers are encouraged to work harder and those who are unable to cope are seen as suffering personal problems. Thus the needs of the organisation are more important than the needs of the individual. Appraisals perpetuate the system by reinforcing the rhetoric.

5.9 The issue of responsibility

Powell presents an ideological image of the unhealthy nursing environment as being a place in which the nurse has the choice of either working in, or leaving. This assumes three criteria:

1. The nurse is financially able to support him/herself,

2. It is obvious that a workplace is classified as healthy or unhealthy.

3. There are healthy environments in which the nurse could work.

By focusing on this stated ability for the nurse to choose between working in a healthy, or unhealthy environment, Powell places all responsibility on the individual. He thus ignores issues of responsibility that the organisation, or those in power, have with regard to providing healthy work environments for their staff. Organisations are not healthy, people are. What is ignored by this perspective is the fact that the people in control of 'unhealthy' organisations do not see their employee's health needs as a priority.

By focusing on the health of organisations Powell omits to talk about unhealthy organisations, except to say that if the individual stays in a unhealthy organisation they are choosing to do so. This is not always the case. They need the money to survive so have to work in all sorts of organisations. This does not exempt the organisations of a duty of care to its employees to provide a safe work environment. By blaming the nurse for the choice of employment this changes the focus and serves as a negative example to other nurses who may suffer similar experiences. It justifies the organisations' need to get rid of people who think differently by labelling them as psychologically unsound, and in need of treatment.

5.10 Conflicting discourses

There are two distinct agendas at work here. The different discourses attribute different levels of blame to the workplace and surrounding social/political structure, with regard to the creation of the problem of burnout. This is an instance of conflict between the two discourses. According to Kress (1985), this situation needs to be

reconciled unless the text is to be seen to be confused and contradictory.

The nurses view is that burnout is caused by stress resulting from the work that they do, and consequently, burnout can be prevented by the support of managers. Nursing managers have the power to address workplace problems (thus relieving the stress of their workers). This contrasts with Powell's view that burnout can be prevented through the application of a psychological strategy called Personal Construct Theory.

In each case there is a model that is implicit in the professionals' attitude which impacts on how burnout is dealt with. Powell believes that nurses should be able to cope with the workload and it is the nurse that needs to adapt to meet the challenge. The nurses believe that the workload has become unrealistic and in spite of many changes it is impossible to meet the workload with the resources available.

Powell states that 'the personal construct approach to stress is used to uncover meanings so that strategies can be evolved which deal with the heart of our specific problems and not with generalities' (Powell 1993, 108). However, the ideological effect produced here is that of shifting the terrain upon which the 'problem of burnout' will be considered from one of being a public issue (i.e. a political problem) to one of being a personal trouble (i.e. a clinical problem). Thus, shifting the focus off issues such as gender inequalities, resource inequalities, and the plight of nurses working in an unhealthy environment. This transformation is made to appear in the text to be both natural and obvious.

This is done through the prior construction of the nurse as a client. In his position of service provider Powell proceeds to help the nurse, who becomes a client who is suffering from burnout, Powell discursively positions the nurse reader into the

position, of choosing the 'treatment' that he prescribe to deal with burnout. By re-articulating the problem to one of the individual nurse needing to become 'more efficient' he discursively manages areas of conflict. His focus is then on supporting the individual to change to better suit the environment, by adapting to her stress and using techniques like relaxation, assertiveness, and negotiation. Where these techniques do not prevent burnout then the individual must 'look deeper' into their psychological constructs. He uses Personal Construct Theory as a way of positioning the reader/client into choosing a more effective way of adapting to the workplace.

5.11 Victim ideology

Powell's perspective is that the nurses need to redefine their personal views of the world to face up to the 'reality' of nursing. He positions the nurses as 'victims of burnout' (Powell 1993, 172). The victim ideology serves to absolve survivors of a sense of blame, but it also unofficially maintains a spectrum of guilt (Wolf 1993). If a nurse was, for example, over-conscientious, or had low self-esteem, then it is her fault that she has put herself at risk of getting burnt out. This positioning resolves the conflict which could arise by the nurse blaming his/her work situation for causing the stress. The label of victim reinforces the power of the labelling authority, that is, Powell (the psychologist), and the nurse is put in a position of having to establish blamelessness.

Powell is very clear that the nurses must face up to the 'facts' of nursing. Powell is not a nurse, yet he is able to stand in judgment of nurses because he aligns himself with medicine. Medicine is seen as being dominant over nursing on the level of

gender, and professional superiority. Medicine is seen as being a male occupation and is dominant over nursing in the health arena. Nursing is seen as a mainly female occupation and medicine as patriarchal. On the intellectual level, medical knowledge is seen as scientific and therefore more valuable than nursing knowledge, which is based on caring and experience. That is, the reality of the economic situation in the workplace. '... nursing has been largely invisible and silent, nurses' knowledge has been poorly investigated, and as an occupation nursing has been minimally understood and poorly valued' (Lawler 1991, 227).

Powell does not define exactly what the reality of the workplace is, as this could lead to possible challenge. By positioning himself as the person who can provide a possible solution to the problems that the nurses have (that is, a solution recognised by doctors, for example Dr Mike Smith on the back cover of the book Powell 1993), and by re-articulating the nurses positions as that of a client, possible conflict is avoided.

5.12 Medical-psychological discourse

Powell employs medical terminology to describe both the individual and the organisation. He uses this as a strategy for eliminating possible sites of antagonism between competing discourses. For example, he advises that 'when it is clear your organisation is a prime contributor to what has happened to you', the 'treatment' metaphorically is to 'remove yourself from its contamination' (Powell 1993, 48). The contamination image draws metaphorically on genre theory, evoking such images as dirt, unsterile surfaces, contagiousness, and so on. Images that all draw upon medical discourse for their meaning, that is, a medical-scientific meaning . In the

chapter, 'Cutting Down the Heat' the metaphors employed largely relate to surgery and medicine, strongly linking the organisation to medical discourse. For example, 'cut yourself off', 'palliative', 'relieve symptoms' (Powell 1993, 41), all reinforce the phrasing of behavioural-medical discourse.

The nurses are framed or constructed as clients in need of 'treatment' for their 'condition', and Powell the expert source of this much needed behavioural-medical first aid.. Given this discursive positioning should the nurse fail to take the 'treatment' prescribed he/she would appear to be resistant, non-compliant, difficult and at fault for ignoring 'expert advice'. Nurses are well socialised into being obedient and Powell is controlling the agenda by selectively ignoring other options. An example of this is the grids that he proposes in the Personal Construct Theory (Powell 1993, 134-135)

By discursively medicalising what is really a political issue, Powell shifts the terrain of the 'problem of burnout' from that of a collective political struggle, to one of individual pathology and treatment. It might be argued therefore that ideologically the problem of burnout is shifted from the realm of being a 'public issue' to that of a 'personal trouble'. This serves to deny that the conditions in the workplace are intolerable, and subordinates nurses to medical control .

Within the text, the client of health care is constructed as a private individual who has needs and desires, is free to choose, and is a decision-maker. This model operates within a process of duelist, predetermined constructed needs. Health care is provided according to the client's perceived needs, but also, these client needs are discursively manipulated to correspond to the services provided by the nominated providers.

By reorganising and restructuring the person suffering burnout as a client, there is the

expectation of improved communication, improved co-ordination and co-operation. It is assumed that once the client's needs have been identified, assessed and met that this will alleviate burnout. The psychological/medical service provider determines what these needs are, as well as what treatment is required, and by whom. The client is not in a position to contest this, as he/she is seen as someone who is unable to cope, and who is suffering some personal inadequacy.

This construction precludes a challenge by nurses suffering burnout because their 'needs' are being met by psychologists. The discourse dissipates the dynamics for change thus supporting the status quo, and the interests of the dominant groups. It functions to alienate people from their capacity to engage in protest. This effectively operates to support the implicit power imbalance and subjects the nurses to further political and economic order.

Within the text Powell positions the reader in such a way that binary oppositions such as healthy/unhealthy, no control/in control, depression/challenge, failure/success, feeling guilty/feeling free, insecure/secure, no time to think/time enough, waste of time/useful, are seen as the most natural ways of exploring the problem of burnout. This excludes other possible options . For example, the nurse may have some control, little control, regular control, etc. over the workplace, as opposed to having either no control or, being totally in control. There is also the possibility that control is not important to nurses. The use of binary opposition positions the nurses as subjects needing to choose a particular service, thus reinforcing their subservient position.

Powell's psychological approach is strengthened by using psychologically determined binary personality dimensions like extroverted/introverted, tough-minded/sensitive, anxious/confident, independent/dependent and conscientious/

expedient (Powell 1993, 151-152). These psychological determinants serve to scientise personality, linking a personality trait to a scientific measurement. Thus reinforcing Powell's position of dominance and intellectual superiority. There is no way of evaluating whether these determinants are appropriate to nurses, as they are prescribed by Powell without any supporting evidence, and there is no real rationale for the prescription or evaluation of the results. Powell has not based his 'treatment' on science but on what he thinks nurses need, based on his psychologist training.

Powell exerts control over the nurses in making them chose from medically dominant areas for help, hiding the control he has over the agenda, and reinforces the opinion that a medical/psychological option is the only option, thus serving the interests of Powell and his colleagues, and devaluing nursing by exclusion.

The process of deciding appropriate courses of action to address the problem of burnout is talked about in a language of strategy. Firstly, assessing the problems as needs. Then, looking at a strategy to resolve the problems and thereby fulfil these needs. Finally resources are mobilised to accomplish the action of fulfilling those needs. The calculation of the levels of stress is strengthened by the scientisation of the process. This method of data collection is not supported by other research, but the association with science is seen as powerful enough. This approach constructs the individual as needing to fit the role of 'normal'. This contradicts the principals of equal opportunity, where there is an effort made to accommodate differences, and value people for these differences.

5.13 Powell avoids addressing differences

The use of case studies, which Powell refers to as 'nurses' stories' is a powerful way of linking nurses to the experiences of other nurses. This serves to position the nurse readers as clients in need of 'treatment' similarly to Powell's nurse clients in the case studies. The use of the case studies has a powerful effect on nurses as they are well aware of the experiences of other nurses. The case studies serve to allow nurses to tell their experiences but position the nurses into situations of helplessness in which they become clients of the service provider. For example, in the case studies one of the nurses is quoted as saying 'I was unable to help myself or even see my problem' (Powell 1993, 23). Powell further depowers the nurses in the case studies by referring to their experiences as 'stories' and this trivialises nurses' experiences. The powerful effect of these case studies is that they serve to reduce the anger of the reader. They unite nurses in their helpless situation of being unable to address their own workplace issues but in need of support and dependent on other professional groups to relieve the problem of burnout.

Powell's use of 'stories' also links his case studies to nursing, as nursing is an oral culture. By focusing on this aspect he re-articulates the oral culture and positions it as being inadequate in resolving issues related to burnout. Powell re-articulates the nursing perspective as being in need of scientific intervention. Nurses are not encouraged to move from the negative position of a client into an empowered position (by taking political action to address the workplace issues). Instead the effects of the workplace are used to control the nurses into accepting that he/she is ill and in need of treatment in the form of medical/psychological intervention.

Nurses are controlled through fears of inadequacy. Those suffering burnout serve as examples of nurses not coping and no-one wants to identify with losers therefore

nurses will agree with the treatment without condemnation. Although workplace issues are known and understood as the cause of burnout they are not addressed by nurses for fear of association with people not coping. For example the nurse who finds herself in a no-win situation. No matter how hard she works, she cannot get job satisfaction or support from her superiors (Powell 1993, 25).

The metaphors of burnout for example, heat, fuel, burning all suggest the need to reduce the condition urgently. The reader is positioned in such a way that the best way of reducing burnout is to use a medical/psychological perspective. The socio-political perspective is discursively re-articulated as a economic rationalist perspective and the lack of resources in the workplace are defined in economic terms as management of resources through effectiveness and efficiency.

Powell's metaphors of contamination are very powerful in nursing culture for nurses are socialised into providing environments that are non-contaminated and nurses have a natural affinity to accept a 'clean' solution to their problems. Thus a nurse choosing to leave an organisation that is contaminated would be doing the 'right thing' even if that impacted on her ability to earn a good wage or it affected her well-being. The use of these metaphors allows Powell's nurse client to accept change to a 'healthier' environment, without questioning the reason for the contamination.

5.14 Powell's limits

Powell's perspectives do not consider issues related to culture or ethnicity. He is using a 'British' approach which he feels is valid in other countries such as the U.S.A., Australia, New Zealand and South Africa, these being the countries he

identifies in the 'Useful Addresses' (Powell 1993, 171-172). In the book there is no mention of different approaches that may be better for indigenous people or people from other cultures. Using such a broad approach is a way of disregarding indigenous people and their perspectives. The nurse who moved out of her position as Ulcer Specialist to a position in a nursing home in the country was aware that different cultures exist within nursing and that the stress levels within those cultures are different. Powell does not recognise that this is so.

Powell does not recognise that nursing is a gender-specific occupation and that women have a different approach to the workplace. He does not mention that women often have home duties and family responsibilities added to their workload. The workplace that Powell promotes does not recognise the roles or responsibility that women experience nor does it address the imbalance of power that women experience in the workplace.

Powell does not address the issue that the workplace serves the interests of those in power being male and the medical model. He ignores the issue of male dominance by assuming the position of helper. Powell's position is one of dominance and he reinforces the hegemony of male power over nurses.

Powell's perspective of nurses are that they are in need of help to address problems in the workplace. At no time does he see nurses as being powerful and having authority to address the power imbalances in the workplace. The nurse must either adapt or leave.

Within the text Powell does not view nurses as being powerful members of society able to address issues related to resource inequalities. He uses his gender and the dominance of his perspective to subordinate nurses and offers solutions to the

inequalities in the workplace as personal maladjustment disorders. The nurse is never encouraged to become political and combine with other nurses to address the problems they face in the workplace. Nurses are not encouraged to become leaders but merely subservient victims in need of his rescue.

By discursively omitting the political and cultural aspects of the problem of burnout Powell prevents nurses from becoming empowered. His text, although heralded as a way out of burnout, serves to reinforce the dominant culture in the workplace and serves to subordinate nurses to that culture.

5.15 Summary

By discursively positioning the nurse, suffering the effects of burnout, in the role of the client, Powell maintains a position of power based on superior knowledge. From the position of a clinical psychologist, he is able to make judgments regarding what the client's problem is, and is allowed to manipulate the problem of burnout from one of social injustices, such as the inequitable distribution of resources, to one of personal problems relating to the individual's psychopathology. He does this, apparently in an effort to help the nurse, based on the concept that you must first accept that a problem exists, before you can set about finding a solution. Although both Powell and the nurses view burnout as a problem, the nurses focus on an external locus of control as being the problem and Powell focuses on an internal locus of control. Powell's re-articulation of the problem corresponds with the solution he wishes to provide. Thus, whether intentionally or otherwise, Powell manages to re-articulate the concept of burnout so that it supports his own agenda, at the expense of the nurse.

The nurses referred to in Powell's case studies indicated that they became 'burnt out' as a result of having to work in increasingly hostile and non-supportive work environments. Such insights could foreseeably translate into political actions such as active union involvement, refusal to continue being exploited, and so on. However, by discursively re-articulating these social (that is, political) issues as personal troubles (that is individual psychopathologies, deficiencies, character weaknesses, etc.) that need to be treated, Powell manages to disperse the potential to see the problem as a political issue requiring political (that is collective) action. Thus Powell, either naively or purposefully, contributes to the depoliticisation of burnout as an important social issue for nurses.

Within the book the preferred way of dealing with the problem of burnout is the psychological model. This model is seen as superior to the social models suggested by the nurses' experiences. Thus addressing the identified psychological needs are believed to be more important than addressing the social needs identified by the nurses in the case studies. The debate between these two possible antagonistic discourses about burnout are ideologically constructed in such a way as to decrease the tension. This is done through the devaluation of nursing knowledge which is based on experience, and subordination to medical/psychological knowledge which is based on science. The text of Burnout is the battleground on which the battle for territory takes place. Social issues are debated and power is exerted, challenged and maintained.

The focus on self-determined treatment is an exploitative approach to interpersonal relationships, and does not take into consideration the complex relationships that occur in the workplace. Although Powell presents an organisational perspective dealing with other staff, he does not explore the complex interactions between these

staff members and the person suffering from burnout. He uses a simplistic approach in which the person suffering from the effects of burnout is not seen as contributing in any way to the workplace. The nurse suffering burnout is not seen as powerful enough to address the workplace issues that contribute to the problem of burnout. This process of denial and exclusion serves to isolate dissatisfied individuals, thus reducing the chance of group political action to address collective issues.

This analysis identified the underlying meanings and ideological effects within the text. These serve to maintain the status quo, that is medical dominance, and control the agenda on burnout. Although the book is publicised as a self-help text it actually serves to reinforce the dominance of medicine in the health arena. Cultural values and practices are communicated through the medical/psychological discourse, and possible areas of conflict are discursively neutralised through the use of managerial discourse, (which reinforces the ideology of economic rationalism, favoured by the dominant groups within society).

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Chapter 6

Beyond burnout

6.1 Overview

Through discourse analysis of a self-help text on burnout it was possible to identify the ideological effects and the power relations involved in the framing of the problem of burnout. While burnout is framed as a personal problem there is little action that nurses can take. The 'problem' becomes a medical condition that is in need of treatment, and this serves to control the individual, and nurses in general, as they do not want to be identified as being in need of treatment. Nurses are thus dis-empowered from taking action for fear of being identified as having a psychological problem of maladjustment. The process of re-articulation of workplace issues as personal problems also serves to reinforce medical dominance and medical ideology as the legitimate way of addressing the problem of burnout in nursing.

One result of economic rationalisation in the nursing workplace is that management styles which support this ideology have been developed . Within these economic rationalist management styles, there is a tendency towards 'blaming the victim' when conditions in the workplace become detrimental to the workers well-being because of increased workloads and limited resources. When workers complain to management about increased workloads, the workplace problems are re-articulated so that they appear to be the result of personal inadequacies, or the worker being psychologically unsound. The individual is thus isolated, and controlled through the medicalisation of the problem, and the nurse is forced to submit to medical/psychological treatment. By focusing on the individual's inadequacies, work conditions that caused the problem are not addressed. This form of management also serves to control the

workplace, for the other workers do not want to be labelled as having psychological problems. They put up with stressful work conditions, rather than being isolated and stigmatised as not being able to cope. This strategy is often employed, as it provides a method of controlling workers during periods of economic restraint and decreased resources. It is a fairly myopic approach, but can nevertheless be used to limit growth in the public service, and also to identify possible future areas for 'cuts' (Napthine 1993).

Analysis of the literature on burnout and the structures of power implicit in the discourse has helped to unravel the reasons why burnout is managed as it is, that is in the bio-medical model. It also illustrated the consequences of this management with regard to those in power, and to the nurse suffering from burnout. While burnout is managed in this way it remains an occupational health issue and the workplace conditions that cause the problem are not addressed.

Health advocacy groups have challenged medical dominance of the health care system, by bringing attention to discrimination, inequality, and poor treatment. However, there is a paradox in the relationship between these groups and scientific medicine. They decry medical dominance, but then allow medicine greater control over the treatment process by calling for increased access to medical treatment (Lupton 1994, 128). As is demonstrated by Powell's (1993) book on burnout, the self-help approach to addressing burnout varies from the traditional medical approach. However it continues to function within the medical framework in the treatment of nurses suffering from the effects of burnout.

Self-help books, along with other problem-solving approaches, have been developed to address issues that may affect nurses. However, all these do is perpetuate the medical model of health and serve to blame the nurse/victim. So far, the political

approach to burnout has mostly been ignored. Thus issues such as, which groups have an influence on how burnout is conceptualised, how the concept of burnout is framed, and who benefits from this framing, are not addressed.

This chapter identifies what nurses can do as a way of addressing the problem of burnout from a nursing perspective. It provides a basic outline of what must be accomplished in order for the workplace issues to be addressed and makes suggestions for nursing strategies to empower nurses on a political level. The discourse analysis of a text exposed the ideological dimensions of the problem of burnout. By exploring how burnout is constructed in contemporary society, and who benefited from this construction nurses are able to understand how to move beyond their present situation and address the problem of burnout.

6.2 Past strategies

In spite of research, conducted by nurses and other scholars, identifying work-related conditions that have a negative impact on nurses well-being, burnout continues to be a problem for nurses. Management strategies have been identified to address the changes that need to occur, but nurses have not as yet been able to move beyond this identification, to actually addressing the problems identified in the workplace. This is related to the lack of power that nurses have in the workplace to address these work-based problems.

Researchers have identified work environments that nurses find stressful, specific work situations that nurses find stressful, and, management strategies that are helpful in reducing nurses' stress in the workplace. There has also been discussion on the

official strategies of dealing with a nurse who is 'burnt out', and these have led to discussion on the social, cultural and political implications of the sickness role.

Otto (1985) reviewed literature on work stress and identified the most crucial predictors of stress and ill-health as, the degree of control people have over their own work situation, and their chances to influence decisions and conditions which affect them. The less control people have over a work situation, the harder he/she will labour under imposed work pressure and close supervision. As well as this, the more likely it is that they will have to perform repetitive tasks which deny them the use of their capacity for versatility and problem-solving. Tasks can also be unsolvable because they imply demands which are either contradictory or not matched by allocated resources (Otto 1985, 13-15).

This argument is supported by the work of Napthine (1993) who discussed how nurses pick up the extra work from other departments to achieve cost savings (a result of reduced staff) without reducing services. In addition to the increased workload, nurses are blamed for not making cuts in their own costs (Napthine 1993, 15-16).

Nurses are also likely to be the subject of management practices which have the effect of reducing the buffers to stress. The effects of the design of individualistic total care nursing excludes and minimises buffers such as peer cohesion and staff support.

The language of stress expresses an ideology varying in both intention and interpretation (Toohey 1995, 55). Nurses define stress as being organisationally determined. This has the effect of suggesting that the organisational structure and culture, determines the success or quality of the individual's working life. The

solution to stress defined in these terms then becomes to address the social issues related to the workplace. On the other hand, if stress is defined in political-economic terms, as is the medical tendency, the solution is to alienate the worker and address stress as an illness needing medical intervention (Toohey 1995, 56-57).

Nursing knowledge and practice has developed out of a meaningful inter-subjective relationship between the nurse and the patient. This relationship is laden with traditions, rituals, and prejudgments which each brings into the situation. Because of its emotional content, nursing work is often stressful. The stress is personal, and questions concerning the nurses' interpretations and actions are seen in isolation, and are seen as unrelated to the structural elements of the health care situation. By focusing on the clarification of the individual's interpretations of the nurse-patient relationship, and ignoring the power relations in the work environment that shape this relationship, nurses are dis-empowered from taking political action (Street 1992, 8).

The work that nurses do is stressful by its very nature and the increase in workloads, driven by the economic climate has increased that stress. Nurses have been socialised into a subservient role, through the nature of their work, which is seen as dirty work, and their role in society as carers is not viewed as powerful.

The health care service has faced increasing pressure to reduce costs and at the same time respond to increasing demands for service. In Australia, this has been reflected in an increasing rhetoric of constraint, and a series of policy initiatives and organisational rationalisations which emphasised the 'wasteful' aspect of public expenditure.

Although much has been written about burnout in nursing and how to manage it,

most of the treatment has centred on the medical model and has been dominated by medical ideology. This has impacted on how burnout has been conceptualised and managed.

Ways of addressing burnout through management have been researched by Branco et al. (1981), Hickey (1985), Constable and Russell (1986), McAbee (1991), and Robinson et al. (1991). In all this research, no single variable was found that proved to be consistent. Arches (1991), however, challenged the assumption that burnout is related to personal problems and suggested that it may instead be related to the broader issues related to the functions of organisations and the power relationships in society. While research focuses on the level of the environment and the individual, the power relationships which allow the social issues to exist are not addressed.

6.3 Political factors

Nurses have traditionally lacked the power and authority to interfere with the discipline of medicine. Medical knowledge is seen as more powerful than nursing knowledge or experience, and nursing, which is seen as a female occupation, is identified with the less powerful tasks of caring (compared to medicine which is associated with the tasks of curing). Burnout cannot be cured in the medical fashion, because from this perspective, the conditions in the workplace are not addressed, and the personalising of the effects of workplace stress merely serve as a powerful deterrent to others not to be identified as having a personality abnormality. This acts to separate possible political action from the main stream of nurses.

Traditionally nurses have seen themselves in an apolitical perspective. Nursing has

supported this apolitical view by its over-subscription to externally-derived understandings of nursing developed through obsequience to the dominance of medical knowledge and practice (Street 1992, 8). Nurses have used the 'vocabulary of complaint' as a way of relieving the stress but this has served to reinforce medical dominance and has not addressed the social conditions in the workplace that cause the stress.

The analysis of the text on burnout presented in chapters 4 and 5 has identified several reasons why nurses have so far been unable to become politically active. These relate to how burnout has been constructed within society, and the hegemony of medicine. The motives behind the ideology being based on the fear, by those in control, that political action could act to undermine traditional roles in the hierarchical structure of health services.

Women's lack of control over the allocation of their time is masked behind an ideology that trivialises and devalues the work that they do. To assist damaged individuals to cope with the extra stress, rather than addressing the structural basis to burnout, management has introduced stress management programs into the workplace. Stress education programs have focused on the role of the individual reducing their own stress rather than increasing the awareness of the structural processes (i.e. political factors) causing the stress. Conditions that caused stress are widely generated by particular characteristics of work environments, even if there are individual differences in the degree to which people experience stress at any given time and place. The cumulative impact of stress-producing conditions in a person's work and life situation can be stronger than anyone's tolerance level (Otto 1985, 13).

Blaming the victim focuses on the individuals' powerlessness, is self-sacrificing, and has a psychology of scarcity and inclusiveness. In the case of burnout, pressure is

focused on the structurally less powerful worker, the nurse (usually a woman), for whom the work pressure has relentlessly increased, and whose control over the work environment has inextricably decreased due to the structure of the workplace and the work overload. Victim mentality can rob women of political strength by using the suffering of one woman to demoralise other women as a political force (Faust 1993). Nurses who are victimised and labelled as burnt out can be used to demoralise other nurses in the workplace and render them powerless.

In the past nurses have used their ability to move to another workplace as a way of dealing with their work-related stress. This is no longer an option available for most nurses for three reasons:

1. Recent developments within health care services have meant that workplaces have become more specialised. This is related to changes in technology, and the development of specialisation along clinical lines. Specialisation has impacted on the individual nurse's ability to move to different areas when work-based problems have impacted on the nurse's well-being as similar positions within the organisation simply do not exist.

2. Restructuring and downsizing has meant that all organisations are structured so that positions are limited and prescribed. This has also affected the mobility of nurses as all positions are occupied and there are no longer free positions for the nurse to move into.

3. Financially, nurses are more reliant upon their salaries, and are therefore locked into their positions on an economic level. Nurses' salaries have increased as a direct result of clinical expertise. Nursing is now more attractive, salary-wise, than many other traditionally female jobs such as office work and caring for

children. One of the negative aspects of this is that nurses who become stressed as a result of work are financially committed. It thus becomes financially difficult to leave one position and move to another as nurses have become increasingly financially dependent on their salaries as a primary source of income.

According to Cherniss (1995), society as a whole has shed its commitment to a moral-religious paradigm and replaced it with a scientific-technical paradigm. The focus of work is based on research, scholarship and rational analysis, and this encourages practice to be critical and detached and weakens a professionals ability to form a strong commitment to an ideology or group.

The professionals focus on individualism and autonomy also undermines moral authority. The influence of the scientific-technical paradigm and its focus on competence and control further dilutes moral commitment and compassion. Therefore it is not surprising that nurses have suffered burnout in the workplace. If nurses are to address the problem of burnout they need to look at developing strong commitments to moral communities and applying research that translates these findings into arrangements that are more suitable for human service programs.

6.4 Empowerment strategies

There are a number of empowerment strategies that have emerged from the review of the literature. They are peer support, addressing workplace problems, new perspectives, and political action.

Peer support

There is no magical quick fix for workplace problems, but all the nurses in Powell's cases studies indicated a need for support from other nurses to address the cause of their stress. If nurses are to move beyond burnout then they must support each other to identify and address the workplace conditions that cause the problem. Nursing, by its very nature is stressful, but nurses are both able and creative enough to address the conditions that cause burnout in nursing, and move from the medically dominant model to a proactive supportive model that serves nursing interests best.

Cox (1996) addresses the issue of peer support in her book *Leading Women*. Her analysis is that few women do support one another because there are few women who are leaders. Leadership is related to power, the concept of which is both confronting, alienating and alien for most women. Power is associated with male attributes and being female is traditionally associated with being compliant, good-natured and nurturing. Women are not encouraged to resist or reject what is socially acceptable (Cox 1996, 26).

Addressing workplace problems

Nurses can no longer ignore the voices of their fellow nurses. It is time for nurses to take on the challenge, and address the issues that cause burnout in nursing, by stopping the fire in the first place. Action can be instigated by individual nurses, managers, educators, or groups such as unions and interest groups, who focus on addressing the problems that occur in the workplace. This can only be done through a process of communication, where issues that affect nurses well-being are communicated and acted upon as a priority agenda for occupational health.

According to Cox (1996, 83) workplaces are 'men made'. By this she means that workplaces command the full attention and commitment of workers and there is little

acknowledgement of other roles such as parenting and household duties. This has resulted in workplaces having the following negative aspects:

- Long hours of expected work allow little time for other activities cast serious doubts on efficiency and effectiveness.
- Workers are discouraged from having contact with family and community.
- Aggressive characteristics in behaviour are encouraged.
- Unreal lifestyles are encouraged, where work exists to the exclusion of family life and participation in childcare and home life.
- Decisions made in the workplace devalue the experience of women.
- Women encouraged to be 'good', and accept without question decisions which are often not in their own interests.

If nurses are to address these workplace issues then it is important for them to develop agendas which include and take into consideration the lives of women and the need to balance home and work. Nurses need to be encouraged to develop skills in the areas such as management. Managerial practices need to recognise the skills that women possess and address the needs of women in the workplace, thus making workplaces more 'women friendly' (Cox 1996, 239).

New perspectives

Nurses must look at the political and social constraints that have prevented them from taking action to address burnout. It is necessary to analyse and critique the medical perspective on burnout contained within contemporary texts and offer other

perspectives which are more supportive of nurses and address the structural issues of burnout. Such critique will expose how the discourse is constructed, and the power structures within the text. This study has challenged the medical notion of burnout, and is an example of how nurses can extend the boundaries of present thought to include social, cultural and political perspectives. Knowledge gained from this will enable nurses to develop strategies for political action to address the workplace issues that create burnout.

Nurses can no longer play the victim, they need to change the systems in which they operate. As Cox (1996, 233) says:

> For the last few years I have become increasingly conscious of the lack of options for us; of the apparent inability of groups, critical of the status quo, to do more than criticise. One of the major faults of many movements has been the lack of explicit plans and goals for progress.

Nurses need to decide what it is in their workplace that needs to be addressed and need to plan and take action to address the issues that affect nurses' wellbeing in the workplace. This action needs to be political and nurses need to address these issues as a united group.

Political action

It is essential for nurses to take political action to address the social conditions that cause burnout to occur. The main issues to be addressed are a direct result of unequal power distribution in the workplace. This is related to a traditional hierarchical structure based on type of knowledge, gender, nature of work, etc. of each group within the occupational division of health services. By questioning the politics within the health division of labour, nurses must challenge issues relating to gender, and the related unequal distribution of power and resources, and thus address the stressors in the workplace which result in burnout.

Cox (1996, 244-245) suggests a type of political action that consists of small reforms rather than total changes. Nurses must extend the agendas of public debates to include what is now seen as private. This will allow them to integrate into policy making all the aspects of daily life that need attention, focusing away from the individual and on the way nurses are connected.

Nurses need to focus on a leadership that looks outwards and manages downwards, and nurses need to value the ideas and visions of those who address changes (Cox 1996, 50). Cox (1996, 252) also suggests a collaborative leadership style which views tasks as different but valuable. This seems to produce more effective and efficient workplaces which are more humane and supportive.

6.5 Conclusion

In order for nurses to address the problem of burnout they must address the political control in the workplace that allows poor working condition to occur in the first place. This can only be done by moving away from the medical approach, which emphasises the individual's problems, and addressing burnout as a social and political issue. Nurses need to move beyond the realms of medical knowledge to include the socio-cultural and political aspects of burnout.

The case studies in Powell's book illustrated the problem of burnout and how it is managed in contemporary society. This is both costly to society, and to nurses, on a personal and a professional level. Toohey's (1993) analysis of stress claims identified that inadequate human resource management was the most common cause of stress, this was also identified by the nurse in the case studies in Powell's book.

The people who are suffering the effects of prolonged stress in the workplace, when they are unable to continue working, must subject themselves to medical scrutiny and diagnosis if they are to claim Workers Compensation. This is not a passive act. Although the person has to submit to the process of labelling, they can take an active role in their treatment by either passively or actively agreeing or disagreeing to it. Medicine has an important part to play in social control, shaping the regulation of human action and the construction of subjectivity.

The provision of health care is politically driven in that it supports the ideologies of the dominant groups. Alternative therapies in health care also support these ideologies, and are in effect extensions of the medical model.

In society nursing knowledge is not seen as being as valuable as medical knowledge because it is experience-based, as opposed to being scientifically-based. However, in the case of burnout nursing knowledge is absorbed and re-articulated as medical knowledge, the nurses' experiences being re-articulated as medical problems in need of treatment.

Occupational health is inherently political in that it is concerned with the relations between capital and labour. In a capitalist economy the health of working people is largely determined by the economic market. Because nursing is seen as a humane, caring profession it is not valued as greatly as medicine which is based on scientific curing. Nurses are dominated within the work force on two levels: nursing is mainly a female occupation, and medicine a male dominant occupation; and on the level of knowledge, medical knowledge being of greater value in our society than nursing knowledge (Gardner & McCoppin 1989, 318).

Nurses have continued to be interested in the problem of burnout, and burnout has

continued to be a problem in nursing. To address the problem of burnout, nurses must address the workplace problems that affect nurses well-being. These work issues are related to a lack of resources, and intrinsically, to the type of work that nurses do. Many nurse researchers have identified that support of nurses is needed, which includes: emotional understanding, the need for regular breaks, supportive environments, debriefing and support to address workplace problems.

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